OVERSIGHT OF HHS INSPECTOR GENERAL'S EFFORT TO COMBAT FRAUD, WASTE AND ABUSE

JOINT HEARING

BEFORE THE

COMMITTEE ON FINANCE

AND THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

NINETY-SEVENTH CONGRESS

FIRST SESSION

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OVERSIGHT OF HHS INSPECTOR GENERAL'S EFFORT TO COMBAT FRAUD, WASTE, AND ABUSE

WEDNESDAY, DECEMBER 9, 1981

U.S. SENATE,
SENATE FINANCE COMMITTEE
AND SPECIAL COMMITTEE ON AGING,
Washington, D.C.

The committees met, pursuant to notice, at 9:40 a.m., in room 2221, Dirksen Senate Office Building, Hon. Robert Dole and John Heinz (chairmen) presiding.

Present: Senators Dole, Chafee, Grassley, Baucus, and Mitchell of the Senate Finance Committee, and Senators Heinz, Cohen, Chiles, Melcher, Pryor, and Burdick of the Senate Special Committee on Aging.

[The press release announcing hearings; background material relating to the Office of Inspector General, Department of Health and Human Services, efforts to combat fraud, waste, and abuse follow:]

Press Release No. 81-182

PRESS RELEASE

FOR IMMEDIATE RELEASE
November 20, 1981

COMMITTEE ON FINANCE
UNITED STATES SENATE
2227 Dirksen Senate Office Bldg.

SENATE FINANCE COMMITTEE SETS JOINT HEARING WITH SPECIAL COMMITTEE ON AGING--OVERSIGHT OF HHS INSPECTOR GENERAL'S ANTI-FRAUD, ABUSE, AND WASTE ACTIVITIES

Senator Bob Dole (R., Kansas), Chairman of the Senate Committee on Finance, announced today that in conjunction with the Senate Special Committee on Aging--Senator John Heinz (R., Pennsylvania), Chairman--the Committee will hold a joint hearing on Wednesday, December 9, 1981, to review the activities of the Inspector General's Office, Department of Health and Human Services in combating fraud, abuse, and waste in medicare, medicaid, social security, and the Federal programs administered by the Department.

The hearing will begin at 9:30 a.m. in Room 2221 of the Dirksen Senate Office Building.

Senator Dole noted that in the mid-1970's investigations by the Senate Aging Committee and others documented that billions of dollars were being lost to program mismanagement and a wide variety of abuses and frauds in the medicare, medicaid, and social security programs. To counter these losses the Congress, under the leadership of the Senate Finance Committee, enacted reform measures which created within HHS (then HEW) an Office of Inspector General, and upgraded crimes against these programs from misdemeanors to felonies. The objective of this hearing will be to determine in which areas those reforms have had a positive impact, and to reveal whether major problems continue to exist in the Federal Government's effort to end fraud, abuse, and waste.

The Committee anticipates hearing testimony from the General Accounting Office, the Inspector General (HHS), and other administration officials.

BACKGROUND INFORMATION RELATING TO

OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF HEALTH AND HUMAN SERVICES
EFFORTS TO COMBAT FRAUD, WASTE, AND ABUSE

Prepared by the Staff of the
SENATE COMMITTEE ON FINANCE
SENATE SPECIAL COMMITTEEE ON AGING
with the assistance of the
CONGRESSIONAL RESEARCH SERVICE

I. INTRODUCTION

The Department of Health and Human Services has responsibility for programs which account for an estimated $230.9 billion in Federal dollars (FY 81). The Senate Finance Committee and the Senate Aging Committee are particularly concerned with Social Security and other entitlement programs which account for approximately 95 percent of total Department expenditures. Allegations of fraud and abuse have been reported for a number of these programs; however, the majority of the committees' efforts to date have focused on medicare and medicaid.

The medicare and medicaid programs, enacted by the Congress in 1965, are intended to help the aged and poor pay for their medical care. Together these programs are projected to account for Federal expenditures of $65.4 billion in fiscal year 1982, an increase of 25 percent over actual 1980 Federal expenditures.

The Congress began receiving reports of fraudulent and abusive practices particularly in medicaid shortly after the implementation of these programs. These reports fostered an ongoing examination by a number of Congressional Committees into alleged program violations. This review led to the passage of several pieces of legislation designed to facilitate Federal and State detection and enforcement efforts and to strengthen program sanctions. The two major pieces of anti-fraud legislation enacted during this period were P.L. 94-505, which established the IG (Office of Inspector General) in the Department of Health, Education, and Welfare (now the Department of Health and Human Services) and P.L. 95-142, the "Medicare and Medicaid Anti-Fraud and Abuse Amendments."

Passage of these bills did not, however, signal the cessation of program violations. The Senate Special Committee on Aging held a hearing in August 1979 which documented many of the same abuses in the medicare home health program which had been cited at a hearing three years earlier. Examples of abuses related to program deficiencies included the failure to deal with discrepancies between the costs of similar agencies providing similar services. Difficulties were also encountered in collecting overpayments from nonprofit providers. Examples of fraud included disguising the non-arm's length relationship between the provider and the entity supplying the service (thereby increasing reimbursement to the provider) and including personal nonpatient related expenses in the cost report. Medicare's cost-based reimbursement was cited as one reason for the existing problems. Difficulties in prosecuting fraud cases, including insufficient resources and complexity of HHS's regulations were noted.

Last year the Finance Committee held a hearing on the investigation conducted by the FBI into kickbacks and other illegal practices in laboratory operations. The hearing raised questions about the effectiveness of the IG in identifying and controlling fraud and abuse in programs under the jurisdiction of the Finance Committee.

Both committees are concerned about the effectiveness of the IG's efforts to combat fraud, abuse, and waste. The effectiveness question was raised again at this year's confirmation hearing of HHS Inspector General Richard P. Kusserow. At that time Mr. Kusserow indicated that the increasing rate at which U.S. Attorneys declined to prosecute cases (66 percent were declined in 1980) required increased IG efforts to develop prosecutable cases and closer cooperation with the FBI. A recent review of the IG's office by the Senate Aging Committee details additional concerns.

The objective of this hearing is to follow up on the past FBI and confirmation hearings to identify weaknesses in existing IG efforts to determine what modifications are necessary.

II. FRAUD AND ABUSE DEFINED

The Congress in its oversight of the medicare and medicaid programs has examined both those activities which can be defined as fraudulent and those which can be characterized as abusive. Fraud is generally defined as an intentional deception or misrepresentation, with the intent of receiving some unauthorized benefit. In the health area, examples of fraud may include: billing for services not rendered, misrepresentation of services rendered, kickbacks, deliberate duplicate billing, and false or misleading entries on cost reports. Providers engaged in fraudulent activities are subject to criminal penalties. Program abuse is less clearly defined and includes activity wherein providers, practitioners, and suppliers of services operate in a manner inconsistent with accepted, sound medical or business practices resulting in excessive cost to medicare or medicaid. Included in the area of abuse are the provision of unnecessary health services and the provision of necessary care in unnecessarily costly settings. Persons abusing programs such as medicare or medicaid expose themselves to various administrative and legal actions, short of criminal prosecution, such as recovery of funds paid and exclusion from program participation. It should be noted that Congressional oversight of program fraud and abuse has focused primarily on provider as opposed to recipient violations. While recipient fraud does exist, generally in the form of misrepresentation of circumstances to gain eligibility, provider fraud is more costly. Loss of funds due to waste is generally the result of the incurring of unnecessary costs as a result of deficient practices, systems, or controls.

The exact magnitude of fraud, abuse, and waste in Department programs is unknown. However, a 1977 report by the Inspector General provided a "best estimate" of total Departmental losses attributable to fraud, waste, and abuse at $6.3 to $7.4 billion. These amounts were later revised to $5.5 to $6.5 billion. The revised estimates for medicare and medicaid programs were $3.9 to $4.2 billion. According to the IG, the majority of these losses were attributed to waste rather than fraud and abuse. Estimated losses due to fraud and abuse amounted to $15 million in medicare and $653 million in medicaid.

III. LEGISLATION TO COMBAT FRAUD AND ABUSE

Beginning in 1972, the Congress approved a number of amendments designed to stem fraudulent and abusive activities, and facilitate detection and enforcement efforts. Most of this legislation was based on the recommendations of the Senate Committee on Finance and the Senate Special Committee on Aging.

A. P.L. 92-603, "The Social Security Amendments of 1972"

P.L. 92-603 established penalties for persons convicted of program violations in medicare and medicaid, such as solicitation, offering or accepting bribes or kickbacks, submission of false claims and making false statements. In addition the Secretary was authorized to suspend or terminate medicare payments to a provider found to have abused the program.

P.L. 92-603 also included several provisions designed to improve administration of medicare and medicaid. While these amendments were not primarily anti-fraud or anti-abuse in nature, it was expected that improved program operations would also curb program abuses. Included in this group are provisions which authorized increased matching for installation and operation of claims processing and information retrieval systems (MMIS) under medicaid, provided for the establishment of Professional Standards Review Organizations (PSRO's), and conformed standards for skilled nursing facilities participating in both medicare and medicaid.

B. P.L. 94-505, Establishment of the Office of Inspector General

P.L. 94-505 provided for the establishment of an independent Office of Inspector General (IG) within the

Department of Health, Education, and Welfare (now the Department of Health and Human Services). The office is charged with (1) conducting and supervising audits and investigations relating to Department programs, (2) coordinating relationships between the Department and other entities relating to both the promotion of efficiency and economy and the prevention and detection of fraud and abuse in Department programs, and (3) keeping the Secretary and Congress informed of its activities.

C. P.L. 95-142, "Medicare -Medicaid Anti-Fraud and Abuse Amendments"

P.L. 95-142 included provisions designed to strengthen sanctions for medicare and medicaid program violations, expand information disclosure requirements, strengthen State fraud and abuse control activities and otherwise strengthen program administration.

P.L. 95-142 redefined most fraudulent acts as felonies, provided for the suspension of individuals convicted of a criminal offense related to their involvement in medicare or medicaid, and clarified the types of financial arrangements and conduct to be classified as illegal. The legislation required institutions and other entities providing services to fulfill certain ownership disclosure requirements as a condition of participation, certification, or recertification under medicare and medicaid.

P.L. 95-142 provided 90 percent Federal matching, subject to specified limitations, for fiscal years 1978-1980 for the costs incurred in the establishment and operation of state medicaid fraud control units.

In addition , the legislation included provisions which (1) required the Secretary to give priority to requests by PSRO's to review services in so-called "shared health facilities" (sometimes refered to as medicaid mills), (2) provided that skilled nursing facilities must assure proper accounting of personal patient funds, and (3) generally precluded the use of power of attorney arrangements as a device for reassignment of program benefits.

D. P.L. 96-226, "General Accounting Office Act of 1979"

P.L. 96-226 added a conforming amendment to P.L. 94-505 which specified that the audit activities of the

HEW Inspector General's office should conform to GAO standards.

E. P.L. 95-272, Social Security Act Amendment

P.L. 96-272 expanded the requirements pertaining to the exchange of information between the Secretary and State medicaid agencies on terminated or suspended providers.

F. P.L. 96-499, the "Omnibus Reconciliation Act of 1980"

P.L. 96-499, included several amendments which modified or clarified provisions of P.L. 95-142. It extended the increased Federal matching payments for the cost of establishing and operating State medicaid fraud control units at the rate of 90 percent for the initial 3-year period and 75 percent thereafter (subject to the same ceilings as under prior law). It also included additional categories of health professionals who could be barred from program participation if convicted of program-related crimes.

P.L. 96-499 also contained several provisions relating to improved administration of the medicare home health benefit. It specified that a physician certifying the need for such services may not have a significant ownership in or contractual arrangement with the home health agency. The law also excludes from reasonable costs amounts attributable to sucontracts based on percentage arrangements.

G. P.L. 96-611, Social Security Act Amendment

P.L. 96-611 provided for a limitation on the ability of individuals to transfer assets in order to gain SSI or medicaid eligibility. The law requires that the fair market value of any resources disposed of in the preceding 24-month period must be taken into account in determining SSI eligibility and may be taken into account by States for purposes of medicaid.

H. P.L. 97-35, the "Omnibus Budget Reconciliation Act of 1981"

P.L. 97-35 authorizes the Secretary of HHS to assess a civil money penalty of up to $2,000 for fraudulent claims under medicare and medicaid and to impose an assessment of twice the amount of the fraudulent claim, in lieu of damages. Whenever the Secretary makes a final determination to impose a civil money penalty or assessment, he may bar the person (including an organization, agency, or other entity) from participation in medicare. He is also required to notify the Medicaid State Agency and may require such agency to bar the person from participation in medicaid. The Secretary may initiate proceedings only as authorized by the Attorney General pursuant to procedures agreed upon by them and may not make adverse determinations until the individual has been provided an opportunity for a hearing.

IV. EFFORTS TO ESTABLISH AN INSPECTOR GENERAL

An Inspector General's office for HHS was considered as early as 1970. In response to problems which had been identified in the medicare and medicaid programs, both the House Ways and Means Committee and the Senate Finance Committee included provisions for an IG for Health Administration in their versions of the "Social Security Amendments of 1970". The bills provided that this unit would have had responsibility for continuing review of medicare and medicaid in terms of effectiveness of program operations and compliance with Congressional intent. Although the bills died at the end of the 91st Congress, the IG provision was again considered as part of the "Social Security Amendments of 1972." The final legislation, P.L. 92;603, contained amendments which provided sanctions for program violations and strengthened program administration, but the Senate amendment to establish an Office of Inspector General was not approved by the Conferees.

In 1975 and 1976, the Subcommittee on Intergovernment Relations and Human Resources of the House Government Operations Committee conducted an extensive investigation into the Department's procedures for preventing and detecting program fraud and abuse. The report of the Committee's findings issued early in 1976 concluded that existing mechanisms were ineffective. The following is a summary of the major findings contained in that report:

1) The magnitude and complexity of HEW activities, aggravated in many instances by lack of direct control over expenditures, present a danger of enormous losses through fraud and program abuse.

2) Fraud and abuse are undoubtedly responsible for the loss of many millions of dollars in HEW programs each year. The committee did not attempt to name a specific figure because HEW officials were unable to provide information on which an estimate could be based.

3) HEW units charged with responsibility for prevention and detection of fraud and abuse are not organized in a coherent pattern designed to meet the overall needs of the Department. There is no central unit with the overall authority, responsibility and resources necessary to insure effective action against fraud and abuse.

4. Staff of most Department fraud and abuse units lack independence and are subject to potential conflicts of interest because they report to officials who are directly responsible for managing the programs the unit's investigate. Further, the Office of Investigations and Security (OIS) may not initiate any investigation without specific approval of the Secretary or Undersecretary.

5) Current organizational arrangements provide little assurance that the Secretary will be kept informed of serious fraud and abuse problems or that necessary corrective action will be taken. The OIS charter does not provide for guaranteed access to the Secretary or Undersecretary. Most other fraud and abuse units report to program officials, usually at a relatively low level.

6) Resources devoted by HEW to prevention and detection of fraud and program abuse are ridiculously inadequate; for example the OIS has had only 10 investigators. Further, HEW has failed to make effective use of its resources. While the OIS has a 10 year backlog of uninvestigated cases, the staff of the Social Security Administration's Investigations Branch has no significant backlog and has 8 investigative positions unfilled.

7) There are serious deficiencies in HEW fraud and abuse procedures. Until recently, HEW had not advised Department employees that they had an obligation to call the attention of appropriate officials to possible violations. Further, there is no HEW-wide policy for centralized supervision of referral actions.

In response to the findings of the House Government Operations Committee, hearings were held on proposals to establish on Office of the Inspector General as an independent entity within HEW. The Committee reported H.R. 15390 on September 14, 1976. The Senate Committee on Government Operations reported H.R. 11347 on September 28, 1976. Title II of this measure, comparable to the bill reported by the House Committee, incorporated an additional provision directing the Inspector General to establish a separate staff to handle investigations involving the medicaid, medicare, and maternal and child health programs. This measure was approved by the full Senate on September 28, 1976, and by the House on September 29, 1976; it was signed into law as P.L. 94-505 on October 15, 1976.

V. P.L. 94-505, OFFICE OF INSPECTOR GENERAL

The Office of Inspector General, Department of Health and Human Services, was the first statutory position of its kind established in the Federal Government. The legislation provided for the establishment of an independent Office of Inspector General within HHS. The mission of the IG is to detect and prevent fraud, waste, and abuse in Department programs and to foster economy and efficiency in their operations.

The IG and his Deputy are appointed by the President with the advice and consent of the Senate. The law specifies that these individuals shall be selected solely on the basis of integrity and demonstrated ability and without regard to political affiliation. The IG is to report to and be under the general supervision of, the Secretary, or to the extent such authority is delegated, to the Undersecretary. He may not be under the control of or subject to the supervision of any other office of the Department. The IG and Deputy IG may be removed by the President, who is required to communicate the reasons for such removal to both Houses of Congress. Though not technically civil service employees, the IG and his Deputy are subject to restrictions against partisan political activity applicable to such individuals. The law requires the IG to appoint an Assistant IG for Auditing and an Assistant IG for Investigations. It also provides for the consolidation and appropriate transfer of existing audit and investigative functions in the IG.

Public Law 94-505 charges the IG with the following duties and responsibilities:

(A) Supervision, coordination and provision of policy direction for HHS auditing and investigative activities.

(B) Recommending policies for, and conducting, supervising or coordinating other HHS activities in order to promote economy and efficiency and to prevent and detect fraud and abuse.

(C) Recommending policies for, and conducting, supervising or coordinating relationships between the Department and other Federal agencies, State and local governmental agencies, and nongovernmental entities with respect to promoting economy and efficiency in Department programs, preventing and detecting fraud and abuse in such programs, and identifying and prosecuting participants in such fraud and abuse.

(D) Keeping the Secretary and Congress fully and currently informed by means of required reports and otherwise of fraud and other serious problems, abuses and deficiencies relating to Department programs; recommending corrective action; and reporting on the progress made in implementing such corrective action.

In carrying out his responsibilities, the IG is to insure effective coordination with and avoid duplication of the activities of the Comptroller General.

In view of the high incidence of fraud and abuse which had been observed in health programs, particularly medicaid, the legislation requires the IG "to establish within his office an appropriate and adequate staff with specific responsibility for devoting their full time and attention to anti-fraud and anti-abuse activities relating to the medicaid, medicare, renal disease, and maternal and child health programs. Such staff shall report to the Deputy."

Public Law 94-505 requires the IG to submit annual reports on the activities of the Office and quarterly reports covering problems and abuses for which the Office has made corrective action recommendations but which in the IG's view adequate progress has not been made. The law also requires the immediate submission of reports concerning flagrant problems or abuses. The IG is authorized to make additional investigations and reports he deems necessary and to provide documents or information requested by the Congress or appropriate Congressional committees. All reports and information must be submitted to the Secretary and the Congress or appropriate Congressional committees without further clearance or approval. The IG, insofar as is feasible, is to provide the Secretary with copies of annual and quarterly reports sufficiently in advance of their due date to Congress to allow a reasonable opportunity for comment.

To assist him in carrying out his reponsibilities under the Act, the law authorizes the IG to (1) have access to all records, reports, audits, reviews, documents, papers, recommendations, or other materials available to the Department relating to programs and operations for which he has responsibility; (2) request any necessary information or assistance from any Federal, State, or local governmental agency or unit; (3) subpoena necessary information, documents, reports, answers, records, accounts, papers, and other documentary evidence (the subpoena to be enforceable by order of the appropriate U.S. district court in case of contumacy or refusal to obey); (4) have direct and prompt access to the Secretary where necessary; (5) inform the Congress when a budget request for the office has been reduced prior to submission to Congress to an extent deemed seriously detrimental;

(6) select, appoint and employ necessary staff; and (7) enter, to the extent provided for in appropriations acts, contracts, and other arrangements for audits, studies, analyses, and other services with public agencies and private persons. Federal agencies are required to furnish information or assistance requested by the IG, insofar as is practicable and not in contravention of any existing statutory restriction or applicable regulations.

A. IG OPERATIONS

The Office of IG is organized with three essential components; the Audit Agency, the Office of Investigations, and the Office of Health Care and Systems Review. The Audit Agency and Office of Investigations reflect a complete transfer of the functions, powers, and duties from the pre-existing HEW Audit Agency and Office of Investigations. The Office of Health Care and Systems Review had no existing counterpart. Although identified as a health unit, this office does not appear to be carrying out the intent of the law for an office "with appropriate and adequate staff with specific responsibility for devoting their full time and attention to anti-fraud and anti-abuse activities."

At the close of 1980, the Office of Inspector General had a staff of 965--23 in the immediate Office of the Secretary and Executive Management, 729 in the Audit Agency, 177 in the Office of Investigations, and 36 in Health Care and Systems Review.

1. AUDIT AGENCY

The Audit Agency has changed little since first organized as an HEW component in 1965. When the IG was created in 1976, all of the functions, powers, duties, assets, and personnel of the then existing HEW Audit Agency were transferred to the IG. The mission of the Agency is to perform comprehensive audits of all Department programs, including those conducted through grantees and contractors, in order to determine whether Department programs are operated economically and efficiently and to provide a reasonable degree of assurance that funds are expended properly and for the purpose for which appropriated. This includes seeing that some 35,000 diverse entities which actually carry out HHS programs receive adequate audit attention. These entities are located across the country and include numerous field installations of the Department, State and local governments, institutions of higher education, medical fiscal agents, and various nonprofit institutions. The Audit Agency conducts a variety of audits, the majority of which are financial in nature and geared to measuring compliance with applicable rules and regulations with particular attention to the allowability of claimed costs. Over two-thirds of the audit reports dealing with

Department programs in 1980 were done by public accountants and State auditors. As a result of Agency audits, some $80 million in proposed adjustments were identified in 1980. That same year, almost $127 million in audit-recommended financial adjustments were concurred with by the program officials. The backlog of unresolved audits as of the end of 1980 amounts to almost $70 million. About $39 million of that amount had been outstanding for more than 6 months--$14 million of which has been outstanding for over two years.

Prior to the incorporation of the Agency into the Office of Inspector General, the Agency had 884 authorized positions. All of the professional staff was accounting or business oriented in education and experience. The Agency staff was supplemented by the use of public accountants and State audit staffs equivalent to about 2,150 staff-years of effort. The Agency considered itself substantially understaffed. This is confirmed in that the number of audits identified as needing to be staffed exceeded the resources available by almost 650 staff years.

In 1981 the Agency had 750 authorized positions. Although the staff continued to be supplemented by other resources, the Agency's workplan for 1981 stated that "(T)here are many areas where no audits are planned--the long-standing imbalance between resources and workload does not allow our doing everything necessary."

2. OFFICE OF INVESTIGATIONS

The Office of Investigations (OI) supervises and conducts investigations relating to programs and operations of the Department. The Office has primary jurisdiction over penalty provisions contained in Title 42, USC (essentially penalties for funds involving medicare and medicaid). In addition the Office has concurrent jurisdiction with the Federal Bureau of Investigation for violations of Title 18 USC (essentially false claims, mail fraud and conspiracy to defraud the Government statutes).

The Office, originally formed as a small centralized unit in 1975, serves as a focal point for alleged cases of malfeasance; fraud; misuse of funds, equipment, or facilities; violations of terms or conditions of finding; and code of conduct violations of employees and other personnel working on behalf of the Department.

The office workload involves cases representing medicare, medicaid, social security and other Department programs. Generally, medicare cases are first identified by the carriers and fiscal intermediaries which process medicare claims. Carriers are required to (1) make payments for covered services on the basis of "reasonable" charges (costs in some instances) in accordance with criteria prescribed by law, (2) establish procedures and provide opportunity for fair hearings in connection with part B, (3) provide timely information and reports, and (4) maintain and afford access to records necessary to carry out the part B program. Intermediaries (1) make determinations of the reasonable costs of covered provider services, (2) make payments to providers for services rendered to beneficiaries under part A, (3) provide financial and consultative services to providers in connection with part A, (4) provide information and instructions furnished by HCFA to providers, (5) make audits of provider records, and (6) help providers with utilization review procedures.

When a carrier or intermediary suspects that a particular situation may involve fraud, a referral is made to HCFA's Office of Program Integrity. After preliminary investigation by OPI, the case is referred to the OI. According to the Memorandum of Understanding between the two offices, the referral is made when a reasonable probability of criminality has been determined. The Office of Investigations completes the investigation and either returns the matter to the Office of Program Integrity for administrative remedies or refers the case for prosecution.

Social Security matters are handled in a different fashion. The Social Security Administration's OPI conducts criminal fraud investigations, prepares cases for presentation to the U.S. Attorney, and assists in the trial preparation of beneficiary fraud cases. Referrals to OI are made when OPI has established that a Federal employee violated the law. Otherwise, based on the cases the staff reviewed, OI only investigates social security-related cases when OI is involved in a joint agency project. For example, Project Baltimore--a joint investigation by OIG, Immigration and Naturalization Service, and SSA focusing on criminal conspiracies to obtain social security numbers for illegal aliens.

Medicaid cases are handled by medicaid fraud control units (MFCUs) in those States where they exist. Federally sponsored, MFCUs are separate from the State agencies that administer the medicaid program. The IG is the manager and national coordinator for all MCFUs. The units rceive complaints of alleged fraud and abuse, investigate and prosecute cases, and collect or refer to a state agency for collection, the program overpayments the units identify.

Twenty-one States do not have Federally sponsored MFCUs although some States operate units which are similar in purpose, but do not qualify for increased Federal matching funds. In States without units, Federally qualified or their own, medicaid fraud investigations are the responsibility of Federal investigators.

The 1980 report of the Inspector General listed 353 HHS cases opened and 145 convictions in that year. The convictions relate to cases opened in 1980 and prior years.

In 1980, 41 health cases were referred to the Department of Justice by the Inspector General. Five of the 41 cases resulted in convictions, all by pleas. The longest period of confinement ordered was 5 months. Of the other cases, Justice declined to prosecute 31, 1 case resulted in acquittal, 3 were pending at the end of the year, and the status of 1 case could not be ascertained.

3. HEALTH CARE AND SYSTEMS REVIEW

The third basic function of the Inspector General's Office is to effect program change to prevent the recurrence of fraudulent and abusive practice. Within the HHS IG, this mission is assigned to the office of Health Care and Systems Review (HCSR). HCSR has a staff of 40.

To accomplish its mission, HCSR staff review audit and investigative findings for program implications. The investigative findings are contained in Management Implication Reports (MIRs) filed by investigators at the conclusion of each investigation. The MIRs identify the cause of the action resulting in the investigation and suggest possible changes in regulations or operations that might prevent a recurrence. When program implications are identified, HCSR transmits their recommendation for change to the appropriate operating division in the Department.

In addition to these reviews, HCSR also undertakes reviews and conducts studies to determine the effectiveness of programs under the Department's jurisdiction.

B. OTHER OPERATIONS

According to a March 23, 1981 survey of resources, some 43 components within the Department share some of the responsibility for promoting efficiency and combating fraud and abuse. Resources in the Department dedicated to these activities totaled 11,321 staff years at a cost of approximately $427.5 million. Of that total, OIG resources accounted for 977 staff positions and $43.3 million.

Chairman DOLE. I might say at the outset that this is a joint hearing of the Senate Finance Committee and the Special Committee on Aging.

We have a number of witnesses today, including a distinguished panel. In lieu of a lengthy opening statement, I will just summarize my opening statement. If other members would do the same, it would save us some time.

The purpose of this hearing is our concern over continuing reports of fraud, waste, and abuse in Federal programs. We know, as the public knows, that each dollar that is siphoned by cheats, frauds, profiteers, and mismanagers means $1 less to meet legitimate program needs, and one tax dollar of the American people wasted.

Because of these concerns, Congress created the Office of Inspector General. There is some concern whether the Office of Inspector General has done much since its creation, and that's an area we want to go into in some detail later this morning.

Medicare and medicaid programs are growing in size. In fiscal year 1982, for example, they will cost about $65.4 billion, an increase of 25 percent over actual 1980 Federal expenditures. We have been through the budget cutting process once in this committee. We are going to have that same opportunity again early next year and perhaps in the following years. Before we affect benefits, it seems to many of us that we have a very deep responsibility to first eliminate fraud and abuse. And I am suggesting fraud and abuse on the provider side as well as on the beneficiary side. That's what this hearing will be directed to this morning.

We have a number of witnesses who, I think, will be very helpful. And we hope to explore in detail what is being done by the administration and what we can do as committees of the Congress.

I certainly welcome to the Senate Finance Committee hearing room members of the Committee on Aging. And I would now yield to Senator Heinz, the chairman of that committee.

[The prepared statements of Senators Dole and Heinz follow:]

OPENING STATEMENT OF SENATOR BOB DOLE, OVERSIGHT HEARING, OFFICE OF INSPECTOR GENERAL, HHS

I am deeply concerned over the continuing reports of fraud, waste, and abuse in Federal programs. Each dollar siphoned off by cheats, frauds, profiteers, and mismanagers, means one dollar less to meet legitimate programs needs, and one dollar wasted from the hard-earned tax dollars of the American people.

Because of these concerns, Congress created the Office of Inspector General. In 1976 the newly created Inspector General was charged with an independent responsibility for the investigation and audit of all department programs. Furthermore, the Inspector General's Office was to provide leadership and direction to the department's efforts to combat fraud, waste, and abuse. The Finance Committee has had a long-standing interest in this matter and as early as 1970 approved legislation to establish an Inspector General for the department's health programs. In fact, the whole statutory concept for an independent office of Inspector General was born out of the poor administrative practices in medicare and medicaid. This became the basis from which the Committee on Government Operations applied the IG concept to all HEW programs. In order to make sure that the original medicare and medicaid concerns were specifically addressed, a requirement was included in the law requiring the Inspector General to establish a specific unit devoted to antifraud and antiabuse activities relating to medicaid, medicare, renal disease, and maternal and child health programs. The committee would like to know what specific actions have been taken by the Inspector General's Office to address the problems in these programs.

Medicare and medicaid are programs which are growing in size and consuming ever larger amounts of Federal and State dollars. Together these programs are projected to account for Federal expenditures of $65.4 billion in fiscal year 1982, an increase of 25 percent over actual 1980 Federal expenditures. We have all been through a very painful budget process and will face a similar unpleasant task next year. I am sure that all of us would like to avoid further reductions in needed services for the elderly, the sick, and the poor.

Stopping the flow of dollars that results from fraud, waste, or abuse should be at the top of everyone's list.

During last year's Finance Committee hearing on the California "LABSCAM" investigation, questions were raised about the effectiveness of the Inspector General in identifying and controlling fraud and abuse in programs under the jurisdiction of the Finance Committee. We are also told that U.S. Attorneys have declined to prosecute fraud cases at an alarming rate not only for HHS programs but Governmentwide.

If I might recap some points made in a recent report by the Comptroller General: Controls over Federal programs are often inadequate, or nonexistent, Federal managers are often unconcerned with enforcing the controls needed to prevent fraud, and once an agency allows fraud to happen, chances are it will never recover the loss. Furthermore, few suspects are prosecuted while agencies fail to take effective action against those who commit fraud.

I know that the President has made the elimination of fraud, abuse, and waste a high priority in this administration. I also recognize that progress is being made on this front by the several Inspectors General in the executive branch. Those accomplishments should be lauded, yet at the same time, it is clear to this Senator that much remains to be done.

Let me say that I believe that fraud, abuse, and waste should be prevented to the extent possible as well as aggressively pursued where such measures have failed. I understand that the Secretary has asked for a comprehensive study of the resources available within the department to do just that. We complement the Secretary on his initiative and look forward to the results of the study. At that time we expect to hear from the Secretary as to how we might be of assistance in determining how those resources are used.

We are here today to learn what has been done, but more importantly, to learn what the Inspector General's Office can do to see that needy citizens, the poor, the helpless, the crippled, the disabled, and the sick are not deprived of the type of assistance that Congress intended to provide through medicare, medicaid, and other entitlement programs.

OPENING STATEMENT OF SENATOR JOHN HEINZ

Sixteen years ago, Congress established the medicare and medicaid programs assuring, for the first time, that quality health care would be available to all of our older citizens regardless of age or income.

But unfortunately, the success of medicare and medicaid has been accompanied by a measure of failure—failure to adequately control fraud, abuse, and waste in the programs.

Over the last 10 years the Senate Special Committee on Aging documented the problems in medicare and medicaid. We found evidence of kickbacks, ping-ponging patients from doctor to doctor, kiting bills, and other abuses. Virtually every provider category was implicated.

At the same time we found considerable evidence of poor care and inadequate treatment—from serious undiagnosed illnesses to extensive patient abuse in nursing homes and boarding facilities.

Estimates of the loss due to fraudulent activities are staggering. In 1977 the committee estimated $3 billion annually was being wasted or stolen from the medicare and medicaid programs alone. Department-wide estimates ran as high as $7.4 billion.

Public Law 94-505, the IG bill, was Congress's way of saying: Enough to those who deliberately sought to defraud these programs; enough to those who sought to waste our meager resources; and enough to those who sought to abuse program regulations. Congress intended to unify the existing fragmented antifraud resources and to commit sufficient resources to the task. It was in this context that the office of IG was created.

This joint hearing by the Senate Committee on Finance and the Senate Special Committee on Aging marks the first formal review by Congress of the performance of that office and its success in detecting, preventing, and controlling fraud, abuse, and waste.

Today, I am releasing the results of a 6-month study of the performance of the IG conducted at my direction by the staff of the Committee on Aging. The 408 page report is entitled "Background Materials Relating to Office of Inspector General, Department of Helath and Human Services Efforts to Combat Fraud, Waste and Abuse" and is dated December 1981.

The results of that study indicate the Office of Inspector General has not operated as Congress intended. Frauds against the Government continue to be lucrative and pervasive. The odds against getting caught and punished are inviting.

Only 5 of 41 health cases the IG submitted to the Justice Department for prosecution in 1980 resulted in convictions. The longest sentence ordered was 6 months.

In comparison with the other 15 Federal Inspector Generals, HHS ranked third from last in the number of cases opened in 1980 per dollar expended.

The office ranked second from last out of the 11 offices with comparable data in dollars recovered per dollar expended in 1980.

The backlog of outstanding audits as of the end of 1980 for HHS amounted to almost $70 million.

The message that has been given those who would abuse the system is clear. The public purse is open and easy, the bureaucracy too ponderous and passive to pursue. The Federal Government continues to squandor billions of dollars through its inability to stop this abuse.

All this must end. The abuse and the inability to prevent, detect, and punish abuse are intolerable. The depletion of valuable health care resources at a time of growing budget restraints on these valuable programs are unconscionable.

We rely on the Inspector General to lead the fight against fraud, abuse, and waste in the Department. Until this year that leadership has been absent and the operation of that office ineffective.

From the committees' analysis, the elements essential to effective operation of the IG are the unification under the IG's leadership of the Department's fragmented efforts to control fraud, abuse, and waste, better targeting of resources, and the elimination of jurisdictional disputes between the IG and various program division within the Department.

Fraud control efforts are not only morally right. They are cost effective. Every report indicates audit and investigatory activities return their cost many times in recoveries. The HHS IG recovers $4.7 for every dollar they spend on audit activities. Today, more than ever, we must find ways to provide needed services while keeping down costs. Improved effectiveness and efficiency in program operation offer an avenue for extending benefits to the needy without increasing overall costs.

To that end, I look forward to hearing the testimony of today's witnesses.

STATEMENT OF HON. JOHN HEINZ, A U.S. SENATOR FROM THE STATE OF PENNSYLVANIA

Chairman HEINZ. Mr. Chairman, thank you. I will be brief, but I would observe that 16 years ago Congress established the medicare and medicaid programs assuring, for the first time, quality health care for older people, regardless of age or income.

But the success of medicare and medicaid has been accompanied by an equal measure of failures—failure to adequately control waste, fraud, and abuse in those programs.

Over the last 10 years, the Senate Special Committee on Aging—which I am privileged to chair—has documented the problems in medicare and medicaid. We have found evidence of kickbacks, ping-ponging patients from doctor to doctor, kiting bills and other abuses. Virtually every provider of category was implicated.

At the same time, we found considerable evidence of poor care and inadequate treatment from serious undiagnosed illnesses to extensive patient abuse in nursing homes and boarding facilities.

Estimates of the loss due to fraudulent activities are staggering. In 1977, the committee estimated $3 billion annually was being wasted or stolen from the medicare and medicaid programs alone. Departmentwide estimates ran as high as $7.4 billion.

Public Law 94-505, the Inspector General bill, was Congress' way of saying enough is enough: Enough to those who deliberately sought to defraud these programs; enough to those who sought to waste our meager resources; enough to those who sought to abuse program regulations.

Congress intended to unify the existing fragmented antifraud resources and to commit sufficient resources to the task. It was in this context that the Office of Inspector General was created.

This joint hearing by the Senate Finance Committee and the Special Committee on Aging marks the first formal review by Congress of the performance of the Inspector General and its success in detecting, preventing, and controlling waste, fraud, and abuse.

Today, I am releasing the results of a 6-month study that marks, during these 6 months, the progress during 1980 that the Inspector General's Office has or has not made. This study was conducted at my direction by the staff of the Special Committee on Aging.

Unfortunately, Mr. Chairman, the results of that study indicate that the Office of Inspector General has not operated as Congress intended. Frauds against the Government continue to be lucrative and pervasive. The odds against getting caught and punished are extremely inviting.

Only 5 of 41 health cases the Inspector General submitted to the Justice Department for prosecution in 1980 resulted in convictions. The longest sentence ordered was 6 months.

In comparison with the other 15 Federal Inspector Generals, HHS ranked third from last in the number of cases opened in 1980 per dollar expended.

The office ranked second from last out of the 11 with comparable data in dollars received per dollar expended in 1980.

The backlog of outstanding audits as of the end of 1980 for HHS amounted to $70 million.

The message that has been given those who would abuse the system is clear. The public purse is open and easy, the bureaucracy too ponderous and passive to pursue. The Federal Government continues to squander billions of dollars through its inability to stop this abuse.

All this must end. The abuse and the inability to prevent, detect, and punish abuse are simply intolerable. The depletion of valuable health care resources at a time of growing budget restraints on these valuable programs is unconscionable.

We rely on the Inspector General to lead the fight against waste, fraud, and abuse in the Department. Until this year, that leadership has been absent and the operation of that office ineffective.

From the committees' analysis, the elements essential to the effective operation of the Inspector General are threefold: First, the unification under the Inspector General's leadership of the Department's fragmented efforts to control waste, fraud, and abuse; second, better targeting of resources; and third, the elimination of jurisdictional disputes between the Inspector General and various other program divisions within the Department.

I believe our efforts to control fraud are not only morally right but they are cost-effective. Every report indicates audit and investigatory activities return *their costs many times over in recoveries.* The HHS Inspector General recovers $4.70, currently, for every dollar they spend on audit activities. Today, more than ever, we really have to find, succeed in finding, ways to provide needed services while keeping costs down. Improved effectiveness and efficiency in program operation offer an avenue for extending benefits to the needy without increasing overall costs.

To that end, Mr. Chairman, I look forward to hearing from our witnesses today.

Chairman DOLE. Are there other members who have an abbreviated opening statement?

STATEMENT OF HON. GEORGE MITCHELL, A U.S. SENATOR FROM THE STATE OF MAINE

Senator MITCHELL. I think this qualifies as abbreviated.

Thank you very much, Mr. Chairman. At a time when present restraints are placing intense pressures on all programs which deliver services to the elderly and the vulnerable in our society, it is appropriate that we take a closer look at the effort to weed out waste, fraud and abuse in such programs.

Americans are generous people. They want our elderly to live in dignity. They do not want children to be punished for the poverty of their parents. They want no one to go hungry in this land of plenty. They believe that decent health care is a basic in this civilized and compassionate society.

That American generosity is the basis for most of the programs that provide assistance which helps pay for medical costs, and which provide income support to children too young to work, the elderly who completed their life labors.

But that concensus on Government's obligation to the vulnerable rests on the base of confidence and trust. The American people must be able—must be confident—that the programs which use tax dollars are, in fact, devoted to serving the needs of the poor.

If we permit pervasive waste to exist, if we allow fraudulent claims to be made against the Government with impunity, we not only divert dollars that could help the needy, but we risk undermining the support of taxpaying citizens for these programs.

So I am pleased, Mr. Chairman, to join with you and other members of this and the other committee in examining in detail the operations of the Government's front line task force against fraud, the Inspector General's program. It is important that we make clear our total commitment to the battle against waste and fraud. And to begin the long and difficult but necessary task of rebuilding public confidence in the integrity of our collective efforts to care for the very young, the very old and the very needy in this society.

Thank you.

Chairman DOLE. Thank you.

Senator Mitchell, we are operating under the early bird rule in this committee. Senator Cohen.

STATEMENT OF HON. WILLIAM COHEN, A U.S. SENATOR FROM THE STATE OF MAINE

Senator **Cohen**. Thank you, Mr. Chairman. I have a prepared statement for the record. I would just like to make a couple of points now.

This is, I think, a hearing in addition to those we have been having in other committees as well. The Governmental Affairs Committee has been rather actively involved in the consideration of the entire issue of fraud and waste. I was going to read this 68 page report, Mr. Chairman, from the Governmental Affairs Committee but I asked instead that the staff to be aware of it. It's compiled by Senator Roth, Chairman of the Governmental Affairs Committee, and it deals with the home health care fraud and abuse problem. He had extensive hearings during the course of this year. And it's a rather shocking report in terms of how easy it is to defraud the Federal taxpayers. It is very easy to determine ripoff schemes.

Yesterday, we had a hearing in the Governmental Affairs Committee, chaired by Senator Percy, dealing with loan delinquencies in the student loan program. And what, I think, came through during the course of those hearings was the question of attitude. There is a mind set or has been a mind set in this Government over the years which represents a great deal of laxity. We found, according to the GAO, in that particular program that the system was in disarray—that there was very little interest demonstrated on the part of HHS, formerly HEW, in collecting loans that were outstanding. There was no policy guidelines that would enable the agency to collect the money. There were no audits, very few audits. And there were no penalties to speak of. A $1 or $2 a month for loans outstanding for many, many years.

So I think this is, perhaps, just a continuation of the oversight responsibilities of Congress to make sure that we do, in fact, change the mind set that it is somebody else's money and we don't really have to exert the kind of oversight that's necessary to make sure it is well spent.

Chairman **Dole**. Thank you, Senator Cohen. I think it is. In the words of the President, he wants the IG to be as "mean as a junkyard dog." I think that was the term.

[The prepared statement of Senator William Cohen follows:]

Statement of Senator William S. Cohen

Mr. Chairman, next to providing for the common defense and the general welfare of all Americans, there is no more important service the government can provide than to guarantee to the American taxpayers that every federal dollar in every federal program is being spent for the purpose intended.

Just two days ago, the President met with his Council on Integrity and Efficiency to receive the second report outlining the campaign against waste, fraud and abuse in government. The Council, consisting of the 16 Inspector Generals claimed in the report that it has already saved the government $2 billion in the last six months. There has been an impressive increase in indictments in federal waste and fraud investigations of nearly 60 percent and an increase in convictions of nearly 30 per cent.

I am pleased that today we will focus on one of the most important areas of all—the Department of Health and Human Services Office of the Inspector General. Hearings conducted by six congressional committees over the last 10 years revealed considerable evidence regarding fraudulent practices in health programs, particularly Medicare and Medicaid reimbursements. As a former member of the House Select Committee on Aging, and as an original cosponsor of H.R. 3; the anti-fraud and abuse legislation that led to the creation of the Office of the Inspector General at HHS, I remember hearing of widespread fraudulent billing practices of some home health agencies in the Medicaid program, as well as patient abuse and mismanagement of public funds in nursing homes. Another House Committee also learned at the time of "extremely serious deficiencies" in the Department's auditing and investigating procedures.

The passage of P.L. 94-505 to create an Office of Inspector General, was intended to correct the problems identified by the Congress in the prevention and detection of fraudulent and abusive activities in program administered by HHS. Because of the high incidence of fraud and abuse which has been observed in Medicaid and Medicare, the legislation directed the IG specifically to establish within his or her office an appropriate and adequate staff with specific responsibility for devoting full time and attention to anti-fraud and anti-abuse activities relating to Medicaid and Medicare.

Progress already has been reported. At the meeting with the President on Monday, HHS Inspector General Kusserow explained how computer list matching techniques have been used to find double-dippers in the entitlement programs. The Office has discovered that millions of dollars worth of Social Security checks have been sent to dead people by cross-checking a list of deceased Medicaid recipients with Social Security lists.

Still, to date there has been no comprehensive Congressional oversight of the Office to determine compliance with the original intent of the law. Why, for example, is the HHS Inspector General's office only rated 9th of 11 other offices in determining cost effectiveness? Why, in comparison with other statutory IG's, is HHS ranked 13th in the number of cases opened in 1980 per dollar expended? Why are 36 per cent of the pending cases listed as six months old or older in the 1980 report, and 21 per cent reported to be over a year old?

I hope these questions will be addressed in this hearing today. I commend both the Chairman of the Senate Special Committee on Aging and the Chairman of the Senate Finance Committee for holding this hearing to examine for the first time both the purpose and the effectiveness of the IG's office.

During my trips back to Maine, I find that my constituents consistently request one thing—that government provide a dollars worth of services for each dollar of taxes. I don't believe that is an unreasonable request. By our actions here today, we can begin to send a signal to people that the Congress is serious about streamlining government programs and reducing waste and fraud to the absolute minimum.

Chairman Dole. Mr. Grassley.

STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM THE STATE OF IOWA

Senator Grassley. Mr. Chairman, this document that Senator Heinz already referred to, and put together by the Senate aging Committee staff, is a fine document. But I want to emphasize and underline what Senator Heinz said that this covers a period of time from the implementing of the regulations until the end of 1980 so the many efforts of the "junkyard dogs" aren't evident in this report because the administration has done its work after the period of time that this report covers.

Upon examination of this document one is struck with the sheer enormity of policing an agency that distributes over $200 billion annually. It may be that this or future Congresses may have to amend Public Law 94-505 to more realistically deal with the realities of administering such tremendous entitlement programs. The Congressional Research Service American Law Division reinforces this possibility in its response to the Aging Committee's questions concerning the autonomy of the Health and Human Services Inspector General; a most telling opening statement of the American Law Division's conclusions reads, and I quote, "* * * neither the statutes nor the committee reports and hearings unambiguously delineate the degree of autonomy Congress intended for the Inspector General at HHS"

Another quote from this report also reads, "* * * It must be noted that the legislative history seems to accord the Inspector General something of a subordinate role to the Department of Justice in criminal investigations."

Since the work of the Aging Committee covers only that period prior to the present Inspector General, Mr. Kusserow, taking office, I am most anxious to read and hear his testimony and find out whether he himself is going to be that sort of a "junkyard dog" that the taxpayers can legitimately demand to see that their taxpayers' money is being well spent.

Chairman DOLE. Thank you, Senator Grassley.

Senator Baucus.

STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM THE STATE OF MONTANA

Senator BAUCUS. Thank you, Mr. Chairman. There has been a lot of talk about waste and fraud and abuse in Federal Government, and, frankly, I think it has been more talk than action by most people who talk about it.

The report, here, that we are discussing this morning indicates that there has been poor performance by the HHS IG's office. I think the record will also show that during the last couple of years, that as much as we have all talked about fraud, waste, and abuse, there really has not been any significant advancement in the area of cutting it out and doing something about it.

It's a difficult question. It's a difficult problem. Unfortunately, some of the best minds in the country are going about trying to figure out how to be fraudulent and how to abuse the system. That means, therefore, that we need the best minds in Government in the IG's offices to prevent it, to root it out, and to formulate programs to minimize it as much as we can in the future.

That goes to the question of the executive pay raise. We need top flight people in Government. That also goes to the question of personnel budgets. We can't cut people out of the IG's offices and out of these departments and think we are going to root out and prevent some fraud and abuse. It just means that dedication is needed to get the job done.

I don't think it's a question of any one administration, whether it's this administration or the last administration. We should blame no administration in my judgment. And I hope this morning that—hope springs eternal—we, during this hearing get to the root of the problem more than we have in the past; that we get the wheels moving finally toward cutting out some of this nonsense so we are not wasting our time here. And I look forward to this morning's hearing with that firmly in mind.

Chairman DOLE. Thank you, Senator Baucus.

Senator Pryor.

STATEMENT OF HON. DAVID PRYOR, A U.S. SENATOR FROM THE STATE OF ARKANSAS

Senator **Pryor**. Thank you, Mr. Chairman. I will not make a statement. I do ask unanimous consent that the full text of a prepared statement be printed in the record.

Mr. Chairman, I would also like to ask unanimous consent that a Washington Post article appearing this morning relative to medicare fraud be printed in the record at this point.

[The prepared statement and article of Senator David Pryor follow:]

Opening Statement of Senator David Pryor

I would like to take this opportunity to commend the distinguished Chairmen of the Senate Finance and Aging Committees, Senators Dole and Heinz, for calling this joint hearing today. There is not doubt that the operations of the Inspector General of the Department of Health and Human Services are of great concern to members of both these committees, and it is very timely and appropriate that we meet to examine that office's functioning.

The Office of the Inspector General of the Department of Health and Human Services was established by Public Law 94-505 in 1976 to identify and combat fraud, abuse and wasteful practices in programs administered by that agency. That office was the model used in 1978 by the Governmental Affairs Committee to establish 16 additional Inspectors General in other federal agencies. In fact, that committee, of which I am a member, is currently exploring the possibility of establishing additional offices in other departments.

There is no question that an office designed for the purpose of ferreting out waste and fraud is a vital necessity in our government agencies, particularly in the Department of Health and Human Services which yearly expends hundreds of billions of dollars. Programs such as Medicare and Medicaid are easy prey for criminal schemes, and require special vigilance.

Yet, despite the established need for such an office, and the fact that the Office of the Inspector General of Health and Human Services was organized at least two years before any other Office of an Inspector General and has the largest staff among Inspectors General, evidence suggests that more must be done in this area. I am hopeful that today we will be able to thoroughly examine the operations of the Inspector General of HHS in our efforts to determine what must be done to make this most important office more effective in doing its job.

I look forward to the testimony of our witnesses.

[From the Washington Post]

Medicare Fraud Keeps Escaping Clampdown

(By Howie Kurtz)

In 1977, the Health and Human Services Department heard that a California doctor had overcharged the Medicare program by more than $130,000 for patients who said they never requested—must less received—his services.

The inspector general's office at HHS did little with the case for three years, then finally referred it to the Justice Department for possible prosecution. But Justice officials decided last year that there wasn't enough evidence to bring charges against the doctor.

This sequence of events is far from unusual. In 1980, the HHS inspector general referred 41 cases of suspected fraud involving doctors, nursing homes, laboratories and other medical providers to the Justice Department. But Justice obtained convictions in only five of the cases, and the longest sentence that any defendant received was five months in jail.

Justice officials decided not to proceed with 31 of the 41 cases, saying they were too old, involved too little money, not enough evidence, or simply lacked what they call "jury appeal." Of the remaining cases, three are still pending, one resulted in an acquital, and the status of one could not be determined.

While some departments have concentrated on recovering federal funds through civil procedures, HHS recovered money in only four of the 31 cases that Justice rejected. At the end of 1980, in fact, HHS had a backlog of unresolved audits involving nearly $70 million, some of which had been outstanding for more than two years. Under the Reagan administration, that figure has grown to $104 million.

President Reagan praised the inspectors general on Monday for pursuing government waste and fraud with the fervor of junkyard dogs, but some observers say their bark may be worse than their bite. While recent figures suggest that the number of cases being sent to Justice is on the rise in the new administration, it is too soon to determine whether this will lead to more indictments and convictions.

Congressional critics say HHS's track record, at least during the Carter years, has given medical providers little concern that they actually will be prosecuted or jailed for Medicare fraud.

Reagan's new inspector general at HHS, Richard P. Kusserow, plans to respond to these criticisms at a Senate hearing today, a department spokesman said. The hearing is being held by the Senate Aging Committee chaired by John Heinz (R.-Pa.), and the Senate Finance Committee, headed by Robert J. Dole (R-Kan.). The spokesman said the department would not comment on the investigations before the hearing.

Some of the cases brought by Justice indicate that physicians often escape with relatively minor penalties. An Illinois podiatrist charged the government for $13,000 worth of foot surgery, for example, when he actually was trimming toenails and removing calluses. He pleaded guilty, was placed on probation for three years and had to repay $5,592.

The toughest sentence was given to an Oklahoma nursing home official, who pled guilty to falsifying 39 monthly cost reports to the government. This official was sentenced to five months in jail, fined $25,000 and ordered to repay $161,000.

Among the cases that Justice dropped was one involving a nursing home official in Washington state and who was accused of accepting at least $25,000 in kickbacks from a meat supplier. Justice officials said they could not calculate the exact loss to the government.

Timely enforcement also was a probem for the government. In a third of the unsuccessful cases, more than two years elapsed from the time HHS began to investigate them to when Justice dropped the case.

An official with the Senate Aging Committee said that investigative efforts at HHS generally have been fragmented among several divisions, and that the inspector general's office now has fewer field investigators than the state Medicaid fraud unit in New York alone.

Senator **Pryor**. And one final observation. We were talking about "junkyard dogs". Just from reading what I have read about the HHS audits and the present condition of the Inspector General, it seems like we do not have a junkyard dog but a pet kitten. And I think that we do need some answers this morning. And I hope that we will get those answers.

Chairman **Dole**. Thank you, Senator Pryor.

Senator Chafee.

STATEMENT OF HON. JOHN H. CHAFEE, A U.S. SENATOR FROM THE STATE OF RHODE ISLAND

Senator **Chafee**. Thank you, Mr. Chairman. I, too, have a statement that I ask to have put in the record.

I would just like to say that these programs we are looking into are extremely important for a host of people in our Nation. I believe in medicare and I believe in medicaid. The problem is to not undermine the confidence in these programs in the citizenry as a whole so that in the attack against waste, fraud, and abuse—those key words that are being bandied around these days—that we don't vituperate and endanger the whole programs themselves.

To insure the future of these programs that are so important, I think what we are undertaking today is extremely important. These are what we call entitlement programs. These two programs, medicaid and medicare, cost the Federal taxpayers $60 billion a year. And now a good portion of that is wisely spent and spent in needy causes. Some of it, obviously, can be saved and is abused. That's what we are looking into today. But I would hate for it to get abroad to the general public or it be bandied about that the whole programs are shot through with these key words of "waste," "fraud," and "abuse," and, therefore, should be canceled. Certainly, that is not the intention of this, Senator. Nor, I suspect of anyone else on this panel.

Thank you very much, Mr. Chairman.

Chairman **Dole**. Thank you, Senator Chafee.

[Prepared statement of Senator John Chafee follows:]

Statement of Senator John H. Chafee

I look forward to the testimony which the witnesses at today's hearings will provide. Fraud, waste, and abuse are dangerous symptoms of either poorly structured programs, or attitudes which permit wanton violations of Government regulations and laws.

As we all know, entitlement programs and uncontrollable expenses account for the vast majority of the Federal budget. Medicare and medicaid alone, cost over $60 billion dollars this year. When one adds food stamps, student loans, workers compensation, and unemployment compensation, the figures become staggering. Some have argued that these programs are too big, that the Government is incapable of running them. As evidence, they point to the widespread abuse of taxpayer's money in all of these programs. Indeed, every new case of fraud which is exposed serves to bolster the argument that entitlement programs and unworkable.

I believe that entitlement programs are workable and are necessary. We have an obligation to provide medical care to the elderly and the needy. In this Nation of abundance, we should be able to make food available to those who would otherwise be without it. And, workers need security to compensate for the hazards of the workplace and the volatility of the economy. Given the size of this Nation, and our generous spirit, some amount of waste in the administration of programs may be inevitable. This does not mean that we cannot eliminate the vast majority of it, or that we whould not work aggressively to reduce fraud and abuse.

There is increasing pressure on the Federal Government to eliminate fraud, waste, and abuse. This is an important effort and I look forward to the observations of today's witnesses with regard to it.

Chairman **Dole**. Senator Chiles, the ranking Democrat on the Aging Committee.

STATEMENT OF HON. LAWTON CHILES, A U.S. SENATOR FROM THE STATE OF FLORIDA

Senator **Chiles**. Thank you, Mr. Chairman. The subject of this hearing is of great interest to me. And I have a statement I would like to insert in the record.

I know that all of us are concerned with this problem. I, personally, have been involved for a number of years and held a number of hearings on it, particularly in home health. And during the last 5 years, we have heard so many times—repeatedly—of what we are going to do to correct the situation. I think a lot of us had such great hopes with the Inspector General, that this was going to be the path that was going to at last allow us to get control over fraud and abuse. But now we see that the Inspector General's office is still plagued by audit and investigative staff shortages with the Inspector General only having 10 percent of the Department's fraud fighting resources, under his control.

We have many unresolved audits. We see from the Inspector General's own report—31 of 41 cases that were referred to the Justice Department for criminal prosecution in 1980 were declined.

That's a terrible batting average That would be terrible in any kind of place. And in Florida, since 1976, there have been over 100 medicare fraud cases that were referred to the Inspector General, and to my knowledge, there is only one of those cases, 1 out of 100, that has some kind of successful prosecution. Cases that have been in the works for over 5 years are still floundering with all of the bickering that has been going on.

Like many of you, I asked for suggestions of what we could do. One of the things the Inspector General said was, "If we just had a statute that allowed us to have civil penalties instead of criminal penalties, we could clean up much of this." Well, I introduced that; we passed that. The Department has that tool. I still don't see how much they are using it.

And, of course, we recognize that. The resources of the Inspector General have been inadequate. Several times I have tried to make appropriations increases that would increase those results from the Inspector General.

I, myself, find it very hard to contemplate or listen to the talk that we are going to cut medicaid and medicare benefits when we haven't been able to do a thing about the rampant fraud that we know is there. And yet we are talking now of having to cut back on the programs.

So I am delighted that these hearings are being held today. I hope that we can get something better going than we have been able to have in the past.

[Prepared statement of Senator Lawton Chiles follows:]

STATEMENT OF SENATOR LAWTON CHILES

I am pleased to be able to take part in these hearings today and I commend the Committee Chairmen for arranging this joint hearing between our two Committees. The Special Committee on Aging and the Finance Committee have a long history of cooperative action, particularly in oversight of the Medicare and Medicaid programs. But this hearing represents a rare instance of a formal joint hearing between the two Committees. I hope we can have more joint hearings.

In a way, we also have a third Committee involved in the hearing as some of us are also members of the Committee on Governmental Affairs which has oversight responsibility for the Inspectors General in most Federal departments and agencies other than the Department of Health and Human Services. Indeed, the legislation we drafted creating these other Inspectors General was based on the model of the Department of Health and Human Services, so I hope we can learn much from this hearing which can also be used to help us improve the operations of other Inspectors General.

The subject of this hearing today is of great interest to me personally. On a number of occasions during the last five years, I have publicly expressed my concern that the Department of Health and Human Services seems to be totally unable to come to grips with massive amounts of waste and abuse within our Federal health programs.

I have been an active participant in uncovering some of this abuse, particularly in the Medicare home health program through hearings of the Special Committee on Aging and the Federal Spending Practices Subcommittee. The last time the Special Committee on Aging took testimony from the Inspector General and the Health Care Financing Administration on progress made in combatting waste and abuse in Medicare was in South Florida in 1979. The Committee received a lot of promises then, and there were grand new plans for action. I want to follow up on the results of this activity today.

We all have great hopes for the success of the Office of the Inspector General. Strong actions to prevent fraud and abuse, particularly in health programs, become more important every day. A strong—and really independent—Inspector General is essential.

But we just don't seem to be able to get off the starting block on this. The report the Aging Committee is releasing today shows that throughout its four-year history, the HHS Inspector General's office is still plagued by audit and investigative staff shortages. That the audit function is fragmented and spread through several agencies within the Department. That the Inspector General himself, though it was intended that the office assume a strong and independent lead in fraud and abuse efforts, really has control over only 10 percent of the entire Department's fraud fighting activities. And that the Inspector General's office does not even set its own priorities for what will be investigated.

There still are too many unresolved audits. One-third of the health fraud cases presented to the Justice Department for criminal action take over two years to develop. And then, when they do reach that stage, it is rare that they go any further. According to the Inspector General's own report, 31 of 41 health cases presented to the Justice Department in 1980 alone were declined. This is a terrible batting average—but I suspect that the actual record is even worse than that.

I have witnessed terrible "turf" problems. Audit and investigative staff are divided between two offices—in the Health Care Financing Administration and in the Inspector General's Office. I don't know if merging these two staffs would solve some of the problems or not—but it has been clear to me for some time that they just can't seem to get together.

At public hearings, the official line of Department witnesses has always been that great cooperative arrangements had been made and that new initiatives were in the works. At the same time, investigators from the Inspector General's office, from the Health Care Financing Administration, and from the U.S. Attorney's office were privately complaining that the lack of progress was because none of the other parties would cooperate with them.

There are two specific Medicare fraud cases in South Florida that I have been following closely—one of them for five years. They both appear to have collapsed amid widespread press charges of bickering among all the agencies involved. "Someone else will not commit their resources." "The regulations are too weak to enforce."

If this kind of thing continues the whole Federal effort against Medicare and Medicaid fraud and abuse will be nothing more than a laughing stock. The Federal Government itself will be guilty of fraud and abuse.

I have personally asked for suggestions from the Justice Department, from the Inspector General's office, and from the Health Care Financing Administration on what Congress could do to help with this effort. When the Department asked for additional authority to make money recoveries through civil action, I introduced a bill to do that and Congress passed it this year. On several occasions I asked for additional funding for the Inspector General's office and for State Medicaid Fraud units in the Appropriations Committee. Those are the only two suggestions I have ever received.

I don't think there is really much more that Congress can do. The Department already has the tools it needs to proceed.

I hope this hearing will help pave the way for a much more efficient and coordinated Department effort to combat waste, fraud, and abuse.

Chairman **Dole**. Thank you, Senator Chiles.

I was looking the other day at what the projected cost of medicare would be by the year 1990, and I found a 1965 estimate. In 1965 they thought that by 1990, medicare costs might reach $9 billion. It is now over $60 billion. Some of that difference is due to inflation, and some is due to fraud and abuse. It is fraud and abuse which can and must be reduced.

The first witness today will be Dr. Richard Kones. Dr. Kones is brought here today by Postal Inspector Terry Loftus, who was the principal investigator involved in making a criminal case against Dr. Kones.

As a precondition to Dr. Kones' appearance, we have agreed to confine our inquires to matters now on the public record. The U.S. attorney's office has requested that Dr. Kones' testimony be presented under oath. Senator Heinz will administer the oath.

[Whereupon, Dr. Richard K. Kones, M.D., was sworn by Chairman Heinz.]

STATEMENT OF DR. RICHARD K. KONES, M.D.

Chairman DOLE. Dr. Kones, would you please state your name and address for the record?

Dr. KONES. Richard Kones, 7443 Tunberry, Houston, Tex.

Chairman DOLE. On September 22, 1981, in the middle of a jury trial, Richard Kones pleaded guilty to 67 counts of an indictment which involved a scheme to defraud medicare, the Department of Labor workers' compensation program, and private insurance companies, by submitting false medical bills worth $1.5 million for reimbursement.

In addition, Dr. Kones pleaded guilty to stealing a $36,000 medicare check from a Houston hospital and transporting it in interstate commerce.

As a condition of his plea, Dr. Kones agreed to pay the United States $500,000 to settle a civil suit which had been instituted against him and his wife for recovery under the False Claims Act of moneys received from the United States from this fraudulent scheme.

Dr. Kones also agreed to resign his medical licenses in 10 States. Dr. Kones I am told has paid the United States the $500,000. And is currently in the process of resigning his licenses.

Dr. Kones was a successful cardiologist who practiced in Pound Ridge, N.Y., until the summer of 1979 when he moved his medical practice to Houston, Tex. While in New York, Kones also maintained part-time offices in Bridgeport, Conn., and at 133 East 73d Street, New York, N.Y. Dr. Kones has published a number of highly regarded books and articles on the heart and was in the process of editing three new publications at the time of his conviction.

From 1977 until the fall of 1980, Dr. Kones, you submitted over $1.5 million worth of false claims for services which you never rendered.

Is that correct, Doctor?

Dr. KONES. Yes, it is.

Chairman DOLE. And as a result, you received at least $500,000 in payments. Is that correct?

Dr. KONES. Yes, sir.

Chairman DOLE. According to the indictment, you would solicit your own patients, claimants for medicare and workers' compensation, and private health insurance policyholders to sign medical claim forms and assignment of benefit forms in blank. Is that correct?

Dr. KONES. Yes, sir.

Chairman DOLE. You would also falsely complete the claim forms by billing for medical and surgical services which you never rendered to those patients. Is that correct?

Dr. KONES. Yes, sir.

Chairman DOLE. And that you usually submitted photocopies of those claim forms on which you stamped a notice in red ink. What did you stamp on those false claims?

Dr. **Kones**. The stamp had something to do with process this as original, I believe.

Chairman **Dole**. Did it say, "Please process this legally assigned claim"?

Dr. **Kones**. Yes, sir.

Chairman **Dole**. And also, "Original submission, process this as original"?

Dr. **Kones**. Yes, sir.

Chairman **Dole**. According to the indictment, you avoided detection by medicare and insurance company computers programed to flag double billings. You did this by rarely double billing for service. Instead, you simply changed the service dates and sent in the identical bill for the same service for a particular patient. In other instances, you would send virtually identical bills for different patients. Is that true?

Dr. **Kones**. Yes, sir.

Chairman **Dole**. Additionally, you often changed the patient's address on the claim form so that all communications with the medicare carriers or the private insurance companies regarding your fraudulent bills would never reach your patients. Is that correct, Dr. Kones?

Dr. **Kones**. Yes, sir.

Chairman **Dole**. During 1979, alone, according to the indictment, you submitted over $1 million in fraudulent medicare claims of which you received $120,000. The claims involved at least 40 patients, most of whom are quite elderly and feeble. In most cases, you only treated the patients on a few occasions with relatively simple procedures, but then submitted false bills indicating multiple visits and complex surgical procedures and claiming thousands of dollars. Dr. Kones, is that correct?

Dr. **Kones**. Yes, sir.

Chairman **Dole**. I want to add at this point, that according to information supplied by the U.S. attorney, the dollar loss by medicare would have been much greater had its contractors, Blue Cross and Blue Shield of Greater New York, not flagged all of Dr. Kones' medicare claims in April 1979.

Blue Cross flagged the medicare claims after receiving complaints from some of Dr. Kones' patients regarding medicare payments to Dr. Kones for treatments which the patients claimed they had never received.

In essence, Blue Cross ceased processing any of Dr. Kones' claims pending further investigation.

According to the indictment, Dr. Kones, you also submitted false claims worth about $120,000 to the Department of Labor's workers compensation program and almost $100,000 in fraudulent claims to five private health insurance companies. Is that correct?

Dr. **Kones**. Well, would you——

Chairman **Dole**. All right. Let me repeat that. According to the indictment, you also submitted false claims worth about $120,000 to the Department of Labor's workers compensation program and almost $100,000 in fraudulent claims to five private health insurance companies. Is that correct?

Dr. **Kones**. Yes, sir.

Chairman Dole. And in addition, you had a scheme which allowed certain lawyers to use high medical bills which you provided plus a fraudulent medical report to promote their clients' personal injury claims, while you would extract money by filing fraudulent claims under available no-fault coverages. By this scheme, you defrauded one insurer of over $60,000 in no-fault claims alone, as well as thousands of additional dollars in personal injury settlements that were inflated due to your fraudulent bills and reports. Is that correct, Dr. Kones?

Dr. Kones. Yes, sir.

Chairman Dole. Now I would have hoped that the indictment ended there, but it doesn't. I would ask Senator Heinz to continue at this point.

Chairman Heinz. Dr. Kones, one of the most intriguing and amazing aspects of your case is your schemes to defraud social security. The U.S. attorney's indictment indicates that you had yourself admitted to a hospital May 16, 1979, complaining of chest pains. Is that correct?

Dr. Kones. Yes, sir.

Chairman Heinz. The indictment indicates you doctored blood tests to reflect heart problems and brought that with you representing it as your own. Is that correct?

Dr. Kones. Yes, sir.

Chairman Heinz. Two days later you checked out of the hospital and the next day you took your first tennis lesson at the Chestnut Ridge Country Club. Is that correct?

Dr. Kones. Yes, sir.

Chairman Heinz. Subsequently, you contacted a cardiologist and asked him to evaluate a stress test you falsely represented as your own. Is that correct?

Dr. Kones. Substantially, yes.

Chairman Heinz. On June 25, on the basis of the cardiologist's analysis of the test, which you misrepresented as your own, you applied for social security disability benefits. Is that correct?

Dr. Kones. Yes, sir.

Chairman Heinz. On the application for these benefits, you substituted your address for that of the cardiologist so that when social security asked for the medical report, you could write your own. Did you indicate you were severely disabled? And did you forge the other doctor's signature?

Dr. Kones. Well, the document did say that I was disabled. And I don't believe there was a signature at all.

Chairman Heinz. How much did you collect for social security?

Dr. Kones. I really couldn't answer that at the moment.

Chairman Heinz. I'm told it was about $1,000 a month for 19 months.

Dr. Kones. Yes, sir.

Chairman Heinz. Then under the pretext of this phony heart attack, you closed your medical practice in New York and moved to Texas. Is that correct?

Dr. Kones. Correct.

Chairman Heinz. In Texas, you applied for two positions. You accepted a $7,500 advance from one potential employer, and went to work for the other, the Alief General Hospital. Is that correct?

Dr. KONES. Yes, sir.

Chairman HEINZ. You were employed by Alief in September of 1979. By May, you were suspended from the hospital for overutilization in billing for services not rendered. Is that correct?

Dr. KONES. Substantially, yes. There were no services that were not rendered.

Chairman HEINZ. All this time you were on 100 percent disability from social security. Is that correct?

Dr. KONES. Yes, sir.

Chairman HEINZ. You were taking tennis lessons three times a week?

Dr. KONES. Yes, sir.

Chairman HEINZ. Did you also file a disability claim with your personal insurance carrier?

Dr. KONES. Yes, sir.

Chairman HEINZ. How much did you receive from the private carriers?

Dr. KONES. I really couldn't say exactly.

Chairman HEINZ. I'm told it's in the neighborhood of a quarter of a million dollars.

Dr. KONES. I think it's probably less than that.

Chairman HEINZ. That's in the ballpark?

Dr. KONES. Yes, sir.

Chairman HEINZ. Did you also steal a check in the amount of $36,185.71 from a hospital?

Dr. KONES. Yes, sir.

Chairman HEINZ. How did you do that?

Dr. KONES. The check was delivered to my office at the time. And it was put through a business account.

Chairman HEINZ. After your indictment, did you violate a judge's restraining order requiring you not to try to transfer assets out of your existing account?

Dr. KONES. I actually didn't violate it, but I wrote certain letters that would have.

Chairman HEINZ. Did you also illegally apply for a passport while on bail?

Dr. KONES. Yes, sir.

Chairman HEINZ. In December of 1980, you were convicted in Connecticut on charges of first degree larceny involving medicaid. What was your sentence?

Dr. KONES. I believe it was a 5-year sentence, probationary and a resignation or what amounted to resignation from practicing medicine in Connecticut.

Chairman HEINZ. Did it also involve the restitution of $30,000?

Dr. KONES. Yes, sir.

Chairman HEINZ. Did you continue to practice?

Dr. KONES. No, I didn't.

Chairman HEINZ. In July of 1981, you were convicted in Westchester County on grand larceny involving your personal insurance claim. What was your sentence?

Dr. KONES. I have not appeared for sentencing yet.

Chairman HEINZ. In 1974, you were indicted and convicted in New York by a district court. What were the charges? Were they in any way different from the present charges against you?

Dr. KONES. No.

Chairman HEINZ. And what were those charges?

Dr. KONES. Medicare fraud.

Chairman HEINZ. And what was your sentence?

Dr. KONES. Five years probation.

Chairman HEINZ. I understand all was suspended but 30 days.

Dr. KONES. Yes, sir.

Chairman HEINZ. How soon after your release, did you resume your fraudulent activities?

Dr. KONES. The bulk of my fraudulent activities did not occur until 1978.

Chairman HEINZ. In September of this year, you pled guilty to 67 counts of fraud. What were the conditions of your plea?

Dr. KONES. Resignation of all medical licenses, settlement of a civil case, as has already been mentioned, and——

Chairman HEINZ. And the restitution of $500,000?

Dr. KONES. Yes, sir.

Chairman HEINZ. I have just one more question, Mr. Chairman, for the moment. Dr. Kones, you stole from medicare, medicaid, workers compensation, social security, your own and five other insurance companies and a hospital where you worked. You forged other doctors' names to bills. You forged your partner's name. You violated your parole agreement, the judge's restraining order, and attempted to illegally leave the country. Is there anyone you didn't try and rip off?

Dr. KONES. Excuse me.

Chairman HEINZ. Is there anyone you didn't try and rip off?

Dr. KONES. I don't know, really, how to answer that.

Chairman HEINZ. Thank you.

Chairman DOLE. It's my understanding, Dr. Kones, that you are willing to answer questions from members of the committees here this morning. Is that correct?

Dr. KONES. Yes, sir.

Chairman DOLE. And I would say at the outset that it's a pitiful case and we are not holding you up to ridicule. We have a responsibility and we need to find out if this is an exception or whether or not this may be rather widespread as far as providers are concerned.

I understand that at the present time, you are assisting authorities in New York in an effort to uncover some of the ways fraud is committed. Is that correct?

Dr. KONES. Yes, sir. My assistance so far has been a review of the medicare codes and certain things that were done that I did.

Chairman DOLE. Do you feel this practice is widespread among physicians and other providers, hospitals or whoever may have medicare or medicaid opportunities?

Dr. KONES. I really don't have any information that would indicate that it is widespread. The system, itself, is fairly vulnerable. And because of the nature of the system, something which I did was possible. But I have no information or beliefs that dishonesty among providers is widespread.

Chairman DOLE. Do you have suggestions on how we might change the system, the medicare system, to prevent the kinds of fraud that you have indicated you committed?

Dr. **Kones**. Well, the wrong doings that related to my case were largely due to individual physopathology on my part. They were not, I think, representative of the medical profession as a whole. Quite the contrary. They were particular problems that related to me. But at the same time, I have made observations about the system in various jurisdictions and I do believe, as I said, that the system is vulnerable. And there are many ways in which advantage of the system could be brought about by providers.

I do have some ideas about what could be done to improve the system that are fairly specific. And that I have already indicated to the officials in the New York region.

Chairman **Dole**. Are those—and I would just say finally because other members want to ask questions—do you have those recommendations or observations in written form that we might have an opportunity to review?

Dr. **Kones**. I don't think that they were put in written form. They were made during the course of several conversations in meetings with the local officials. I'm fairly certain—all I can do is I might be able to contribute what was discussed with those gentlemen.

Chairman **Dole**. Right. I am informed by Senator Heinz that you have indicated a willingness to work with our committee staff, the Aging Committee and the Senate Finance Committee, in effect, to restate those observations. And it will be helpful if you can as we try to find ways to prevent fraud and abuse under the programs.

Dr. **Kones**. Let me, if I could, state that, again, my situation is due to an individual problem. And as a result of that, I can honestly state that what I did was, in all circumstances, wrong. As a result of my feeling in this area, I am willing to use whatever expertise I have and the time available to me to help this committee or any other body help the system.

Chairman **Dole**. Thank you, Dr. Kones. Senator Heinz is going to make another try.

Chairman **Heinz**. Dr. Kones, these are four books you have written. According to every available evidence, you are a brilliant physician. You are listed in Who's Who in North America. You were consulting editor to three medical journals. You had a legitimate income in excess of $100,000, but now you face a considerable prison sentence, the loss of your medical licenses and your reputation.

I understand that all this started in 1974. That's when you were first convicted for 1971 offenses. Is that right?

Dr. **Kones**. Yes, sir.

Chairman **Heinz**. And since that time, you have essentially kept up a business on the side of defrauding medicare, medicaid, social security, private insurers. And that was after you had been convicted, 2 years after you got out of school. You weren't caught again until 1980. But as I understand it, most of that time, you were engaged in a series of illegal activities to defraud one part or another of the Government or the private insurance industry. Is that more or less right?

Dr. **Kones**. Well, it is true that such activity took place during those times. But they did occur in modes of activity. They occurred at points in my life which I deeply regret and which were not under my control. But toward the end, it got so that these episodic or impulses of activity were so close to one another that it almost looked like a continuing one.

Chairman Heinz. How did you avoid being caught again until 1980 when you were caught the first time in 1974? What did you do differently between 1974 and 1980?

Dr. Kones. Well, the Lord's knows that the way that I did it with these forms—and I sincerely believe it is designed to relate authorities—I was completely grandiose in my behavior.

Chairman Heinz. If you just send enough forms, it is easy to fool the system. Is that what you mean?

Dr. Kones. That's right. There were so many areas. Well, actually, I was really testing the system as a symbol of somebody else in my life time. But the point was that these forms were so arrogant and outrageous that the services could not possibly have been performed where I alleged they were performed. The diagnoses that I put down didn't relate to either the services or to other diagnoses that were submitted at the same time.

The totals on the forms were outrageous. The forms, themselves, were photocopies. They were clearly copies of services that we used for other forms and other patients at the same time.

Chairman Heinz. I understand that you simply photocopied the same form over with the same information on it many, many times, just putting different names at the top. Is that true?

Dr. Kones. Yes; these occurred in frenzies of activity when I actually did not really have that much control over what was going on.

Chairman Heinz. I'm not focusing so much, Dr. Kones, on what you did. We have focused already on that. I am focusing on all these claims that went off to medicare and medicaid and they were almost obviously run off on practically a duplicating machine. Is that correct?

Dr. Kones. That's exactly true.

Chairman Heinz. And that added up to millions of dollars.

Dr. Kones. Absolutely true.

Chairman Heinz. One last question. Is there any reason—you seem to have chosen medicare. You seem to have concentrated on medicare. Is medicare tough to cheat?

Dr. Kones. It wasn't a choice. It was just at that time in my life when that was—so the target or victim, who it was going to be, it just happened by chance. I was a doctor and they were the authorities. But it is simultaneously true and interrelated that the system is extremely easy to evade.

The forms that I sent in were absolutely outrageous. And when I relate this story to public figures or it is related to me by people who are familiar with them, it's a source of merriment.

At one time, I made a list of 16 categories of flags on the forms. Sixteen features of the forms that I sent in that should have alerted authorities to the type of forms that they were, in fact. Unfortunately, the system was that vulnerable.

Chairman Heinz. I find that absolutely remarkable. Sixteen different flags. Somebody had been convicted in 1974 and it took 6 years for anyone to find it.

Chairman DOLE. Thank you, Senator Heinz. I recognize Senator Mitchell and then Senator Cohen, Senator Grassley, if he returns, Senator Baucus, Senator Pryor, Senator Chafee, Senator Chiles, if he returns, and Senator Burdick.

Senator MITCHELL. Dr. Kones, are you now in custody?

Dr. KONES. Yes, sir.

Senator MITCHELL. You were convicted of a felony in September of 1974 and most of the events described here this morning occurred after that. You filed claims with a number of Government agencies under a number of Government programs. After your conviction in September of 1974, did anybody representing any agency of Government ever inquire of you in anyway as to whether or not you had a prior criminal record?

Dr. KONES. No, sir; I might say that I was not receiving reimbursement for a substantial period of time after that. And there was a good deal of work that I had done for these patients in a legitimate way that was more or less forgotten. But I bring that up not because I harbor any special feelings about that but because it may be of use to you to know that I was not practicing within the system several years after that. Despite what the indictment alleges, I am adding to that now voluntarily by saying that these forms past that were actually dated for services in 1976 or so, so that to the casual observer, it might look as if there was a continuing of activity according to the dates. But at that time, I was not participating in the program.

Senator MITCHELL. But nonetheless, you had been convicted of a felony, you did file claims in the millions of dollars, and according to your testimony here this morning, nobody representing the Government ever at anytime asked you the simple question, "Do you have a prior criminal record?" Is that correct?

Dr. KONES. That's correct. They did not.

Senator MITCHELL. And would you recommend that, based upon your experience, as one specific recommendation that perhaps makes some sense that when any individual provider files a claim for reimbursement that somebody from the Government be charged with the responsibility of inquiring of that provider in some fashion as to whether or not that person had a prior criminal record?

Dr. KONES. Yes, sir; I believe that would be of value.

Senator MITCHELL. Had that simple question been asked of you and the record of your 1974 conviction been brought to the attention of someone in Government, that might have prevented all of these subsequent activities. It would have been to your benefit as well as to the Government's, would it not have been?

Dr. KONES. Yes, sir.

Senator MITCHELL. Now you mentioned other recommendations that you had made. And I know you are going to submit them later in writing. But could you tell us specifically, based on your experience, what you think the most important one, two, or three recommendations you would make to prevent this from occurring again with respect to someone else?

Dr. KONES. I need to collect my thoughts for a moment to order them in priority.

I might preface with the remark that because of this offense, I do have considerable expertise in not only medicine but in the workings of these programs. And in the course of my dealing with the New York representative, I made it clear that with some expertise in both areas, I would make myself available, open-ended. In fact, I don't know how this is going to turn out. And I don't know in what fashion I am going to be punished.

But I do have a very positive motivation to rather spend that time for good. And work specifically to improve the program. Myself, I don't see where—if my punishment were made, for instance, to sit in prison for a certain number of years, it wouldn't really do me or society that much good. I am very resourceful.

And I understand some of the things that have been problems that I had absolutely no insight about all the time.

Senator **Mitchell**. But that's not the subject of this hearing. I would merely point out to you, however, that society has an interest in appropriate punishment that goes beyond the individual in the case.

Dr. **Kones**. Yes, sir.

Senator **Mitchell**. And that is, of course, the principle of deterrents in the interest of society in not permitting this kind of activity to go unpunished so that others wouldn't be similarly tempted in the future. That's not the subject of this hearing. I don't want to stem that.

Is my time up, Mr. Chairman?

Well, I won't pursue it then. I hope perhaps that in response to some later question that you will give us some specific recommendations. We haven't had those yet.

Chairman **Dole**. Senator Cohen and then Senator Baucus.

Senator **Cohen**. Would it be appropriate to inquire what the titles of your next three books might be?

Dr. **Kones**. Well, I have actually—I was editing and had in my possession about seven books of materials. The publishers of those books have requested that they be returned to me and they will not publish them.

Senator **Cohen**. I fully expect you to be a candidate on the program "That's Incredible" at some future time as to how you were able to engineer this. And we will probably have a book about how you were able to be successful in your endeavors.

But I would like to come back to a point raised by my colleague, Senator Mitchell. It seems there is something underlying here. Both of us have had experience as former prosecutors. And one thing that strikes me, Mr. Chairman, is the disparity in treatment in this particular case. And I would suggest that it is indicative of a disparity and inequity that exists in many other cases. I can recall prosecuting men for stealing $500 or $1,000 who got sentenced to 2 to 3 or 5 years in jail.

You have stolen hundreds of thousands of dollars, maybe millions of dollars and you end up with a 30-day sentence that you actually had to serve. That strikes me as being incredible.

I mentioned the Governmental Affairs hearings that we had. We had hearings a year ago in the chop-shop operations where people steal cars and chop them up. It's about a quarter of a million dollars income tax free for each person involved. We had hearings this year and still have hearings scheduled on drug smuggling into this country. It's a $1 million income for the pilots per year. We talked last year about the home health care agencies, and this little diagram shows you how easy it is where an individual can set up five phony, not for profit, home health agencies with five subcontractors all owned by the same person.

And it seems to me that the problem is that nobody is watching. Nobody is watching. And I could go on and on with debarments, suspensions in the Defense Department, for example, and other agencies where a contractor can be debarred for committing fraud against the Federal Government and walk right across the street and go into another agency and get a new contract. And there was no prohibition against that until recently.

What I think is indicative in all of this, whether it's medicare or medicaid or chop shops or drug smuggling or home health agencies, is the following: Little risk of detection. What we saw here was a man going on for years in a most flagrant—you called it grandiose—kind of behavior, illegal behavior. There is little risk of detection; little risk of prosecution; little risk of conviction; and very little risk of severe punishment. And you balance that against the huge profits, and I think that explains why we have so much difficulty with our system today.

I would be happy to hear the kind of recommendations you have for correcting the loopholes and the inadequacies in our system. I suspect it will make for better interesting reading, better than the Congressional Record and perhaps better than the popular talk show. But I look forward to hearing your specific recommendations as to how you would recommend that we have somebody watching over the medical profession as such. You say you don't know whether your behavior is representative of the problem.

The hearings I have attended to date reveal it's so easy—so easy—to rip off our system. And there is so little incentive to discourage that, so little in the way of disincentive for punishments, that I would suggest that we actually have a reverse situation. Saying, look, there's a big pile of money down in Washington; no one is really looking; there's very little risk of getting caught. And when you get caught, you'll get a 30-day suspended sentence and the restitution of the money you stole. That, to me, is part of the problem.

Chairman DOLE. Senator Baucus.

Senator BAUCUS. Thank you, Mr. Chairman. I would like to follow up on the questions that Senator Mitchell was trying to ask.

Dr. Kones, as I understand, you want to make yourself available and help out. And as I understand, you hope that helps you when the judge attempts to pass sentence. As Senator Mitchell pointed out, that's not the subject of this hearing. We don't have any authority in that area. And you alone can't help root out some of these problems, you can't be the policeman that is always going to be there.

Could you tell us, though—now that you have had time to collect your thoughts—what one, two, or three of the most telling recommendations, the most important recommendations that you have to help prevent these kinds of abuses from reoccurring?

Where is the system most vulnerable?

Dr. **Kones**. I believe that as a prerequisite for accruing some of the problems in all the programs, that there are a number of sequential moves that have to be made. The first is some uniform system of coding in all regions. At the present time, the medicare program and the medicaid program, and in this case, the Department of Labor's workers compensation program, all have different administrative requirements for filing claims and use such a variety of systems for presenting claims to the carriers that no uniformity now exists from which a reduction of waste can occur.

I have done a lot of thinking about this over the past year. And I always come to the same conclusion that before a certain improvement can be made in any of these programs——

Senator **Baucus**. Uniformity among different State jurisdictions as well as among different Federal programs, as well as uniformity between State and Federal programs?

Dr. **Kones**. Right; because there are now, perhaps, 50 different code systems that are in use by different carriers for different programs in different regions. And the great benefit on a national scale that would accrue would be from making all these programs subscribe to a particular code.

Senator **Baucus**. Is it easier to defraud States or is it easier to defraud the Federal Government?

Dr. **Kones**. Well, I am no authority on it.

Senator **Baucus**. I thought you might be. [Laughter.]

If you are not, who is?

Dr. **Kones**. I am laughing at the sadness of the thing because my case is not representative of what is going on.

Senator **Baucus**. Oh, but you are kind of an expert.

Dr. **Kones**. Well, it may be. I can only speak about this area.

Senator **Baucus**. Based on your experience.

Dr. **Kones**. My personal experience has been that they are about equal.

Senator **Baucus**. Equally easy to defraud or equally vulnerable?

Dr. **Kones**. The system, as it exists in the areas as I see, is fairly wide open.

Senator **Baucus**. What about the competence of Federal personnel in trying to prevent these kinds of abuses? Do you find them competent or not competent?

Dr. **Kones**. Well, substantial improvements could be made. I must say that I was equally astounded when some of these payments were made.

Senator **Baucus**. So you are saying they are not competent?

Dr. **Kones**. My psycopathology in my case made me to want discovery, so I deliberately made my forms so outrageous that they begged for a discovery.

Senator **Baucus**. You are saying that even if someone tried to be more careful in using the system, that person could get by more easily than you, who sent in outrageous claims.

Dr. **Kones**. Absolutely. The attention that my case has gotten has only brought about the nature of the forms, these 16 flags, that existed. There is no way I or anybody else could make forms more lucidly fraudulent, for instance, presented to a carrier. I don't think that anybody even with considerable effort could make it more obvious.

Senator BAUCUS. My time is up. I want to thank you.

Chairman DOLE. Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman.

Doctor, I am prepared to accept you as an expert witness today here in this area. And take it that what you are telling us is that it doesn't require a special knowledge or special expertise to accomplish what you did. That it's open to any or what we might call "run of the mill" doctor. Is that true? Run of the mill in the expertise of which you are preeminent.

Dr. KONES. Well, yes, I would have to say yes.

Senator CHAFEE. Keep it simple. Is that true?

Dr. KONES. It is but I don't have, as I say, any knowledge particularly that——

Senator CHAFEE. We are not saying that—we are not accusing. But what you are telling us is that it is quite simple for a person less ambitious than you to raise 16 flags who could have accomplished on a more moderate scale that you accomplished without alluding the authorities quite so visibly. Is that true?

Dr. KONES. Yes, sir. Yes, sir. Absolutely.

Senator CHAFEE. Let me ask you a question here. The problem in all these programs is the balancing between the simplicity and the swiftness of the delivery of the services against the potentiality of abuse. The way to avoid all abuse is to have stack upon stack of so-called red tape, check and check and check. The reverse side of that is you delay the delivery of services, the swiftness of the payment from the carrier to the hospital or the doctor or whoever it is, the provider. So now we have to balance these off.

In other words, it seems to me that there could be some fraud if the services are going to be delivered with relative swiftness.

Dr. KONES. I don't want to be presumptuous and disagree——

Senator CHAFEE. No; maybe I'm wrong.

Dr. KONES. I am adding to your observation. I, for one, think that the next step after making the codes uniform would be then to get down to the business of work. The difficulties, the vulnerability, within these programs I think is conferred by the fact that the programs themselves are not—well, actually inadequate as it is now.

Senator CHAFEE. They are not inadequate or they are?

Dr. KONES. Grossly inadequate.

Senator CHAFEE. The programs?

Dr. KONES. The computer programs for various series in all subspecialties are grossly inadequate.

Senator CHAFEE. You mean in locating abuse?

Dr. KONES. Not so much locating abuse but in simply having adequate flags and having adequate frequency stops and having other stops that—for instance, reject certain services when others are being done. The situation, as it exists now, is so inadequate that I don't believe revamping what now exists in any region would give any substantial saving or any increase in detection of abuse of various kinds. I don't believe that it's worthwhile for anybody to, for instance, commission computer people to come into one program and say please program me a fee manual and a pay technique that is tight on ridding the system of abuse, but yet delivers adequate services to the population within a necessary period of time.

I don't think that prompt service and good medicine and the Government getting what they paid for are all mutually exclusive. I believe that a major overhaul, housecleaning, is in order for all the programs. And it does not have to be done and duplicated within each region. All it has to be done is once, well. And if that was done on a national scale, it would take care of the problem in a very simple way forever.

And I also have ideas about simple ways that it could be done by people who are experts in their specialties.

Senator CHAFEE. Well, my time is up, but, of course, that is what we are seeking here. It goes beyond, I take it, a uniform code system. You say you have ideas. A specialist within each of the medical fields, I suppose, could bring this thing up to snuff without delaying a delivery of services or infringing on the swiftness of the payments to the deliverers.

Dr. KONES. Absolutely.

Senator CHAFEE. Well, I look forward to that being pursued.

My time is up, Mr. Chairman.

Chairman DOLE. Thank you, Senator Chafee. Senator Pryor.

Senator PRYOR. Thank you, Mr. Chairman.

Doctor, there seem to be two incredible aspects of this entire case. And one is that you would or could get away with this amount of money without being detected. And the other incredible aspect that I sense is that the Inspector General of HHS seemingly did not recognize what was going on. At what time sequence in the scenario of your activities did you first encounter someone from the Inspector General's office of the Department of HHS?

Dr. KONES. It wasn't until I indicated my willingness to examine certain procedures, certain administrative requirements of the local medicare carrier in the Greater New York area.

Senator PRYOR. Are you saying that the Inspector General's office did not contact you affirmatively? I mean you did not voluntarily call up the Inspector General and say, "I would like to tell you what I have done, and how my suggestions might be forthcoming to correct it." You didn't do it in this way?

Dr. KONES. No, sir. You are quite correct.

Senator PRYOR. Did the Inspector General investigate your case?

Dr. KONES. I have no knowledge of that. This is the first I have heard of the Inspector General or his interest in my situation or his interest in what I have to say. I have not heard the words "Inspector General" verbalized.

Senator PRYOR. You have been defrauding the Government and the taxpayers for all this number of years and today is the first day you have heard of the Inspector General of the Department of HHS?

Dr. KONES. Yes, sir.

Senator PRYOR. I'm speechless, Mr. Chairman. [Laughter.]

I can't believe it.

Chairman HEINZ. Senator, I might point out that the gentlemen accompanying the witness are from the postal department which speaks better for the mails than any of our constituents.

Senator PRYOR. Let me add a word while I am speechless. There is legislation relative to strengthening the postal inspectors effectiveness in pursuing mail fraud.

Chairman HEINZ. I thought the Senator might want to bring out the Pryor-Heinz legislation.

Senator PRYOR. Right. [Laughter.]

I was about to put in a pitch for another piece of legislation that I am interested in. That is the creation of the Department of Inspector General in the Department of Defense. But after just receiving Dr. Kones' answer, I'm not sure that we need at least a similar department to this Department. I certainly think we do need an Inspector General of the Department of Defense, but I think you really need to examine the aspects of it.

Mr. Chairman, I am going to yield back the balance of my time.

Chairman DOLE. Thank you, Senator Pryor.

Are there any other questions of this witness?

[No response.]

Chairman DOLE. We have a number of other witnesses. Dr. Kones, we thank you for coming.

Senator Melcher, do you have any questions of Dr. Kones?

Senator MELCHER. No, I do not. Thank you very much.

Chairman DOLE. Thank you, Dr. Kones. Our staff will be visiting with you in an effort to find out more detailed information. Is there anything else you want to say for the record at this point before leaving?

Dr. KONES. No. Other than that I do have some definite ideas. And I do have a positive motivation to help. I just cannot see all the waste in the system when it just has to be done properly, and it could be done within a year's time by somebody who is intimately familiar with medicine, knows how to coordinate medicine to benefit the public, and use it as the available resources in the American boards of each specialty to better the medical service to public. I sincerely believe in that. And I am willing to cooperate in any way that I can.

Chairman DOLE. Thank you, Dr. Kones.

Chairman HEINZ. Mr. Chairman, just let me join as chairman of the Aging Committee in thanking Dr. Kones for coming down here. We have made the point today that it is not easy to get caught when you defraud medicare and medicaid. It is also not easy to do what Dr. Kones has done in coming here and telling us everything that he has told us. And, Dr. Kones, I do want to express on behalf of all of my colleagues on the Aging Committee, a large number of whom, in fact, are here, have been here, our appreciation.

Dr. KONES. Thank you, Senator.

United States of America v. Richard J. Kones
SS 81 Cr. 120 (PNL)

Background Statement

On September 22, 1981, in the middle of a jury trial,Richard Joseph Kones pled guilty to sixty-seven counts of Indictment SS 81 Cr. 120 which involved a scheme to defraud Medicare, the Department of Labor Workers Compensation Program and private insurance companies by submitting false medical bills for reimbursement. Additionally, Kones pled guilty to defrauding Social Security by applying for and receiving Social Security disability benefits. Finally, he pled guilty to stealing a $36,000 Medicare check from a Houston hospital and transporting it in interstate commerce. As a condition of his plea, Kones agreed to pay the United States $500,000 to settle a civil suit which had been instituted against Kones and his wife for recovery under the False Claims Act of monies received from the United States from his fraudulent scheme. Kones also agreed to resign his medical licenses from the ten states where was was licensed. Kones has already paid the United States the $500,000 and is currently in the process of resigning his medical licenses.

Kones was a successful cardiologist who practiced in Pound Ridge, New York until the summer of 1979 when he moved his medical practice to Houston, Texas. While in New York, Kones also maintained part-time offices in Bridgeport, Connecticut and at 133 East 73rd Street, New York, New York. Kones also published a number of highly regarded books and articles on the heart and was in the process of editing three new publications at the time of his conviction.

I. Fraud Scheme

From November 1977 until the fall of 1980, Kones submitted over $1,500,000 worth of false claims to various private health and accident insurers and government agencies for medical services which he never rendered. Through this scheme, he received at least $500,000 in payments.

Typically, Kones would solicit patients of his who were Medicare claimants, Workers Compensation claimants or private insurance policyholders to sign medical claim forms and assignment of benefit forms in blank. Kones would thereafter falsely complete the claim forms by billing for medical and surgical services which he had never rendered to his patients. These false claims most frequently included surgical procedures relating to the treatment of heart disease, surgical removal of rectal polyps, and arthrocentesis (infiltration of a joint with an instrument).

Kones would usually submit photocopies of claim forms on which he stamped in red ink "Original Submission Process This As Original" and "Please Process This Legally Assigned Claim." In many cases, Kones simply changed the service dates and sent in the identical bill for the same services for a particular patient. In other instances, Kones would send virtually identical bills for different patients. Despite the numerous fraudulent bills submitted by Kones, he rarely, if ever, double billed for a service - thus avoiding detection of his scheme by insurance company and Government agency computers programmed to flag double billing.

Kones would submit the false claims on patients who were least likely to discover or compromise his scheme, including many elderly Medicare recipients, Spanish-speaking patients who spoke little English, and accident victims who had a monetary interest in injury lawsuits. Additionally, Kones often changed the patients' addresses on the claim forms so that all communications from the Government agencies or the private insurance companies regarding his fraudulent bills would never reach his patients.

Kones also submitted false medical reports to the Government agencies and private insurance companies in which he falsified the seriousness of the condition of his patients and the nature of his treatment. These medical reports were usually sent by Kones in response to requests by the various agencies and insurance companies for explanations from Kones concerning the nature and size of his bills. Upon receipt of Kones' false reports, most of the companies and agencies were satisfied and did not contact their insureds or beneficiaries before paying the claims.

A. Medicare

During 1979 alone, Kones submitted over $1,000,000 in fraudulent Medicare claims for which he received approximately $120,000. The claims were largely submitted in the first six months of 1979. The dollar loss by Medicare would have been much greater had its fiscal administrator, Blue Cross and Blue Shield of Greater New York, not flagged all of Kones' Medicare claims in April 1979.* The Medicare claims involved at least forty patients, most of whom were quite elderly and feeble. In most instances, Kones only treated the patients on a few occasions with relatively simple procedures but then submitted false bills indicating multiple visits and complex surgical procedures and claiming thousands of dollars.

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* Blue Cross flagged the Medicare claims after receiving various complaints from some of Kones' patients regarding Medicare payments to Kones for treatment which the patients claimed they had never received. In essence, Blue Cross ceased processing any of Kones' claims pending further investigation.

B. Department of Labor

Kones received $120,344 for claims submitted on Peter Beccaria to the Department of Labor's Workers' Compensation Program. The bills were submitted for two separate injuries that Mr. Beccaria, a rural letter carrier, sustained on the job. Although both injuries to Mr. Beccaria were relatively minor and required a total of approximately a dozen office visits to Kones, Kones billed for 227 visits during which he claimed to have performed, among other procedures, 159 central venus pressure procedures (insert catheter into heart cavity), 208 paravertebral nerve blocks, 224 arthrocenteses, and 71 flouroscopies (heart x-rays).

C. Private Insurance Companies

The Indictment named just five of the many insurance companies that were victimized by Kones' scheme.

1. Health Insurance Carriers

Blue Cross, Government Employees' Health Association ("GEHA"), Transworld Life Insurance Company and Metropolitan Life Insurance Company provided health plans pursuant to which Kones submitted assigned claims for medical treatment. During the course of the scheme, Blue Cross paid Kones over $41,000 in fraudulent claims*; GEHA over $20,000; Transworld over $18,000; and Metropolitan over $20,000.

The Blue Cross claims involved at least thirty patients, many of whom had not been treated by Kones for years. He would simply change the dates on old claim forms and resubmit them as new 1978 and 1979 claims.** Since Kones was a participating physician, all of the payment checks were mailed directly to him.

In addition, Kones, a Blue Cross policy holder, submitted false claims to Blue Cross for reimbursement for treatment purportedly rendered by another physician to himself and family members. Kones used a signature stamp of his partner, Dr. Vincent Sica, which he affixed to these false claim forms on which he additionally indicated that Dr. Sica's fee had been paid. In fact, Dr. Sica never treated Kones or his family members. Kones billed Blue Cross over $10,000 and received over $2000 for these false reimbursement claims.

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* Kones submitted to Blue Cross over $300,000 in fraudulent claims during the scheme. The dollar loss by Blue Cross would have been much higher had it not discovered the scheme and flagged his claims in April 1979.

** Kones kept copies of these fraudulent Blue Cross and Medicare claims in a Houston apartment which was searched on May 5, 1981 pursuant to a federal search warrant. The seized records included a number of master bills which Kones used to submit for a number of the patients. Also located were notes by Kones indicating which dates per patient had already been billed and which additional dates and procedures were to be billed.

The GEHA claims concerned treatment for Peter Beccaria and his wife, Margaret, as well as for another postal employee, Jack Follis. In each case, GEHA wrote Kones inquiring as to the size of the bills. Kones submitted fraudulent medical reports on each patient wherein he outlined the seriousness of their medical problem. In Follis' case, Kones wrote: "This patient is literally two heartbeats away from a fatality ... I did not feel that he would be alive today." Kones cautioned the Company not to advise the patient of his condition, and, as a result, the Company continued to pay the claims. Of course, Follis is still alive today and quite well.

Whereas the Blue Cross claims involved many different patients, the claims at Transworld and Metropolitan* involved only one patient for each company.

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* Kones also defrauded Metropolitan of $9500 in its medical examiner program by issuing self-pay drafts to himself for examinations he never rendered. This fraud was covered in Count Ninety-Seven of the Indictment. In essence, Kones was at one time a medical examiner for Metropolitan. As such, he would conduct medical examinations of prospective insurance clients of Metropolitan. Metropolitan issued self-pay drafts to its medical examiners to complete for reimbursement. Although Kones was terminated in February 1978 by Metropolitan as a medical examiner, as a result of a computer error, Kones continued to receive self-pay drafts which he fraudulently filled out and negotiated.

2. Accident Insurers [State Farm]

Kones had a scheme with several accident lawyers regarding phony medical bills. The lawyers would send their accident clients to Kones who would then run up high medical bills. The lawyers would use the high medical bills plus a fraudulent medical report from Kones to promote their clients' personal injury claims, while Kones would extract his money by filing fraudulent claims under the available no-fault coverages. By this scheme, Kones defrauded State Farm of over $60,000 in no-fault claims alone as well as thousands of additional dollars in personal injury settlements that were inflated due to Kones' fraudulent bills and reports.*

II. Social Security Disability Scheme

On May 16, 1979, Kones admitted himself to St. Lukes Hospital complaining of chest pains and shortness of breath. He came to the hospital with his own blood test results, which indicated a massive heart attack.** The blood tests conducted by the hospital proved negative. Kones' EKG was normal at the hospital. Against the advice of his doctor, Dr. Miles Schwartz, Kones checked out of the hospital on May 18. On May 19, Kones first took a tennis lesson at the Chestnut Ridge Tennis Club and then travelled to visit Dr. Jesus Yap, a cardiologist. He related the story of his hospitalization to Dr. Yap. Dr. Yap's examination was also negative as to a heart attack. Dr. Yap rescheduled Dr. Kones for 2 weeks to take a stress test. Kones then contacted Dr. Joel Strom, yet another cardiologist, to evaluate a stress test which he falsely represented to be his own. The stress test was, of course, grossly positive of a heart attack. Subsequently, Kones gave Strom's written evaluation to Dr. Yap and Social Security as evidence of a heart attack. In July 1979, Dr. Yap examined Kones a second time. Once again, his examination was negative as to a heart attack.

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* The other accident insurers defrauded by Kones included Allstate, GEICO, Maryland Casualty, Empire Mutual Insurance, Statewide Insurance Company, Chubb Group, Fireman's Fund, Consolidated Insurance Company, Great American Insurance Company, Upjohn Medical Group, Royal Globe Insurance, and Colonial Life Insurance.

** Kones has subsequently acknowledged that he doctored his blood tests by adding an enzyme which is indicative of a heart attack.

Kones applied on June 25, 1979 for Social Security Disability Benefits on account of the alleged heart attack. On the Social Security application, Kones listed the address of his doctors, Dr. Schwartz and Dr. Yap, as "133 E. 73rd St., Community Medical Offices." The address was actually Kones' own business address. Social Security then sent a letter to Kones' doctors at the listed address for a medical report on Kones' heart condition. Kones actually wrote the report and returned it to Social Security. The report itself indicated that Kones was severely disabled from the heart attack. Based on the fraudulent report, Kones was granted Social Security Disability Benefits. As a result, Kones and his family fraudulently received about $1000 per month for the 19 months he was on the Program. Finally, in August 1981, Social Security terminated his payments due to his refusal to take a redetermination examination.

Kones used the phony heart attack to close his New York medical practice and move to Houston, Texas. In June 1979, he sent his patients and many of the insurance carriers a letter advising of the termination of his practice due to his heart attack. The letters to the insurance companies advised them of his financial plight and asked for consideration on any outstanding claims.

Kones' contempt for the system was especially blatant with respect to Social Security. Not only did he continue his vigorous tennis schedule as described below, but also he was actively engaged in moving his medical practice to Houston at the very time he was reporting his 100% disability to Social Security. In fact, he travelled to Houston on June 27, 1979, two days after he applied for Social Security, to interview with Alief General Hospital and the Yale Clinic. He subsequently accepted a $6000 per month guaranteed position with the Yale Clinic.*

Kones left New York in August 1979 and resumed his medical practice in Houston in September 1979 at the Alief General Hospital. Kones maintained his own patients and served as a cardiology consultant at the hospital.** Kones also was on the staffs at Rosewood General Hospital (November 1979 thru October 1980) and Southwest Memorial Hospital (January thru October 1980) where he both admitted his own patients and served as a consulting cardiologist on other doctors' patients.

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* Actually, Kones did not report to work at the Yale Clinic when he moved to Houston. Instead, he opened an office at the Alief General Hospital. However, he did receive a $7500 advance from the Yale Clinic which he never returned and which is the subject of a lawsuit by the Yale Clinic.

** Kones was suspended from Alief General Hospital in May 1980. He was charged with over-utilization of diagnostic tests and procedures and with billing for services not rendered. He was also accused of charging to the hospital various purchases of hardware items for personal use.

In addition, Kones was an avid tennis player who played tennis two to three times per week in the years following the phony heart attack. For example, Kones took twenty-three tennis lessons at the Chestnut Ridge Tennis Club in the three months he remained in New York following the phony heart attack.

Throughout this period, Kones never advised Social Security of his employment or physical activity and continued to draw monthly Social Security Disability checks.

In addition to Social Security, Kones also filed disability claims with his own insurance carriers for the heart attack. In all, Kones collected over $250,000 from his private carriers for disability from the heart attack. It was for these fraudulent private disability claims that Kones was convicted in Westchester County in July 1981.

III. Alief General Hospital $36,000 Check

While employed at Alief General Hospital, Kones stole a $36,185.71 Medicare check payable to the hospital. Using a stamped endorsement of his business "Community Medical Offices," Kones deposited the check into his account at the New York Bank for Savings. He subsequently withdrew the money and opened a $36,000 securities account with Merrill Lynch.*

IV. Other Criminal Activity

a) Prior Convictions

In September 1974, Kones was convicted of a similar Medicare fraud scheme before Judge Lloyd F. MacMahon who sentenced him to a 5 year jail term with all but thirty days suspended and a $30,000 fine. The 1974 conviction covered criminal activity in 1971 and 1972.

While on probation from the federal conviction, Kones committed many other crimes, including most of the crimes to which he pled guilty in the instant case. Apparently, the probation department was unaware of the additional criminal activity and therefore did not seek to revoke his federal probation.

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* Kones also stole an $1,831 private insurance check payable to Dr. P.J. Curtis of Alief General Hospital, which he also deposited into the Community Medical Offices' account at the New York Bank for Savings. Kones explained during his plea that the checks were misdelivered to his suite.

In December 1980, Kones was convicted on state charges of first degree larceny in Connecticut for Medicaid fraud. The charges arose from criminal activity in 1975 and 1976. Kones received a 5 year suspended sentence and was ordered to make restitution to Connecticut in the amount of $32,574.90.

In July 1981, Kone was convicted of grand larceny in Westchester County arising out of his submission of fraudulent disability claims to his own insurance carriers, which claims rendered him $250,000. Kones will receive a 1 1/2 to 3 year sentence as a result of a plea bargain.

In addition, Kones is under indictment in Houston, Texas for check kiting charges involving over $70,000 worth of checks.

b) Judge Gagliardi Restraining Order

On February 20, 1981, Judge Lee P. Gagliardi entered a temporary restraining order that enjoined Dr. Kones and his wife from "transferring or disposing of any assets presently in their individual or joint names..." The restraining order remained in effect through March 6, 1981.

Kones was incarcerated at the Metropolitan Correctional Center ("MCC") during the pendency of Judge Gagliardi's order. From the MCC, Kones engaged in a scheme to liquidate several accounts in contempt of the order. He instructed his former secretary to send mailgrams purportedly from his wife Sandra Kones to Citibank and Manhattan Savings Bank which authorized the banks to liquidate the accounts and give the proceeds to Richard Kones. He also instructed his secretary to follow up the mailgrams with letters to the banks using the signature stamp of Sandra Kones. Apparently, Sandra Kones was unaware of these activities. The Citibank account contained almost $600,000 worth of gold holdings in the name of Sandra Kones and her children. The Manhattan Savings Bank account contained a $35,000 certificate of deposit in the name of Sandra Kones. A copy of the mailgrams and letters are attached as Exhibits 1 thru 4.

c) Passport Violation

On September 16, 1981, Kones applied for a passport at the New York Passport Agency. On the passport application, Kones originally stated that he had never been issued a passport. Eventually, he produced a May 6, 1964 expired passport as his last issued passport. Kones went on to advise the processor that he intended to leave the United States as soon as possible. Kones, of course, was on trial at the time and, as a condition of bail, had previously turned over his passport to the United States Attorney.* Upon notification from the State Department of Kones' passport application, our office immediately moved this Court for the revocation of Kones' bail, the issuance of a bench warrant and his remand.

The Government based its request in part on the movement by Kones of almost $1,000,000 in assets from the United States to Bahamian accounts after his indictment. Ironically, this money included almost $600,000 from the Citibank gold accounts which Sandra Kones herself liquidated in late March 1981, shortly after the lifting of the restraining order, and immediately signed over the proceeds to Kones for deposit into his account at the Nassau Branch of the Bank of Montreal.

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* Originally, Kones turned over passport # A782405 in the name of Richard J. Kones with a April 13, 1985 expiration date. In its investigation, the Government discovered that Kones also illegally had another passport under the name of Ivan Joseph Kones. Kones subsequently surrendered passport #A1502423 of Ivan Joseph Kones to our office.

d) Credit Cards

At the time of his arrest in January 1981, Kones had over a hundred Master Charge and Visa accounts in his or his wife's name. In addition, he also maintained ready money or credit accounts with at least forty banks across the country. Kones literally had hundreds of thousands of dollars worth of credit at his fingertips. The credit cards themselves were often obtained under false pretenses, since Kones misrepresented his residence to be in the city where the banks were located. For example, some of the banks were located in Florida, New Jersey, Ohio, Georgia and California.

Since his arrest, the Government has received dozens of requests from banks across the country regarding the whereabouts of Kones, due to large unpaid credit card and ready credit balances. Based on these reports, we estimate that Kones currently has overdue credit card balances in the neighborhood of $500,000.

It appears that Kones was engaged in a kiting scheme wherein he opened new ready credit and credit card accounts to pay off existing accounts. Kones reveals his fraudulent purpose with the credit cards in some papers which were seized from him at the time of his arrest, wherein he notes as to Master Charge and Visa: "Try for cash advances in progressively smaller amounts But review each to see that they are not overdue ... must be current [can pay c bounce check but catch on day 1 or 2 of crediting]." He also noted: "Keep ... cards going as long as possible ... those up for renewal (1/81, 2/81, 3/81, 4/81) pay until renewed ... keep up those to use in Europe-Mexico ... Go out with them overlimit."

V. Proceeds from Crimes

Kones profited enormously from his criminal activity. He went from debt in 1975 following his 1974 Medicare fraud conviction to several million dollars net worth in 1980.* He lived an extravagant lifestyle. For example in 1980 alone, Kones wrote over $150,000 in checks for day to day expenses from his Merrill Lynch checking account. He could have never supported this lifestyle from his medical practice alone and still continued to devote so much time to the unprofitable business of publishing learned journals.

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* By the fall of 1980, Kones had over $800,000 in securities and treasury bills in Merrill Lynch accounts as well as over $800,000 in gold holdings at Citibank and with the International Gold Bullion Exchange. In addition, Kones had over $100,000 in holdings with Twentieth Century Gold Investors, Kansas City, Missouri as well as over $100,000 with Securities Fund Investors, St. Petersburg, Florida. He also had accounts at E.F. Hutton valued at over $150,000. According to Kones' pocket diary, he also had $100,000 deposits in separate accounts at the Eastern Savings Bank (Scarsdale, N.Y.), Barclays International Pioneers Way (Freeport, Bahamas), Citibank (Nassau, Bahamas), and Chase Manhattan Bank (Freeport, Bahamas). Significantly, except for the Bahamian accounts and a few small domestic accounts, all of Kones' holdings were placed in the names of his wife and children.

Chairman **Dole**. Our next witness will be Mr. Charles A. Shuttleworth, chief of investigation, California Department of Health Services.

STATEMENT OF CHARLES A. SHUTTLEWORTH, CHIEF INVESTIGATOR, CALIFORNIA DEPARTMENT OF HEALTH SERVICES

Mr. **Shuttleworth**. Good morning. Chairman Dole, Chairman Heinz, and members of the committees.

Chairman **Dole**. I understand you have a brief statement which will be made part of the record. You can or summarize it and then you are going to show us some——

Mr. **Shuttleworth**. A video tape if you wish, sir.

Chairman **Dole**. Yes.

TESTIMONY

UNITED STATES SENATE

FINANCE COMMITTEE AND COMMITTEE ON AGING

HEARING ON EFFORTS TO COMBAT FRAUD, WASTE, AND ABUSE

WASHINGTON, D.C. - DECEMBER 9, 1981

CHARLES H. SHUTTLEWORTH
CHIEF INVESTIGATOR

CALIFORNIA STATE DEPARTMENT OF HEALTH SERVICES

Chairman Dole, Chairman Heinz, and members of the Committees, I appreciate this opportunity to present an overview of an ongoing investigation of Medicaid fraud within the State of California and related areas. I hope the information will provide the Committee with a greater understanding of program fraud and California's efforts to combat it.

Approximately, two-thirds of all criminal complaints filed against Medi-Cal beneficiaries in California involve some form of drug abuse. In view of this large monetary drain from the program and the adverse consequences of drug abuse, the Department has been focusing its investigative efforts in this area.

Earlier this year, the Department of Health Services Investigations Branch was contacted by an informant who told us about an organized group that was acquiring narcotics under the Medi-Cal program by subterfuge and deceit. The subsequent investigation, which has been in process for nearly a year, revealed some rather startling facts.

A group of approximately 400 Medi-Cal beneficiaries were acquiring large volumes of drugs for self consumption, for sale, or for trade with dealers for hard narcotics or weapons. The operation of this particular group was centered in

Bakersfield, California. The program "patients" would travel long distances from all over the southern part of the state to work the scam. One hundred miles one way was not unusual. The dollar cost to the Medi-Cal program of this "Desert Drug Ring" was upwards of $500,000 annually and involves approximately 1½ million pills each year. The street value of the drugs acquired from the program has been estimated at $6,000,000 during the period. The drug ring was in operation for the past three years and worked with unusual boldness. Leaders would organize five to ten car caravans of Medi-Cal beneficiaries to visit doctors' offices for prescriptions. Afterwards, when a car was filled, it would proceed to pharmacies to obtain the drugs. The drugs were frequently sold or traded in the pharmacy parking lot. Other times, the caravan would drive out of town and into the desert to conduct business.

The providers and organizers of the group were noted to drive Cadillacs, Mercedes and other luxury vehicles. Many of the dealers and smaller traffickers displayed all sorts of diamonds and gold jewelry.

Program recipients were recruited in an open manner. The leaders of the drug ring moved into the community and concentrated their efforts in ghettos and poorer neighborhoods. They offered free narcotics, cash, and in some cases, weapons in exchange for merely using the recipients Medi-Cal health card. Many of the Medi-Cal beneficiaries were alcoholics and/or drug abusers and were easily enticed by the offer.

State investigators, together with officers from the Los Angeles Sheriff's Department, filmed a day's events beginning with the patients arrival and formation at the physician's office all the way through to the actual possession of the drugs. On this particular occasion, 20 persons waited for the doctor to arrive and when he did, all 20 were "examined" within 40 minutes, and were on the road to the pharmacy. The drivers received a cash bonus for each trip, apparently to defray the cost of personal vehicles. When either you or I have a prescription filled, we generally receive one, two, perhaps three containers which fit easily in one hand. The 20 persons in the film exited the pharmacy with large grocery-type bags filled with drugs.

In this particular case, the drugs, largely purchased with taxpayer-financed Medi-Cal money, included Dalmane, Valium, and Seconal, and when combined with codeine, give the user an effect similar to heroin. Doriden is another drug commonly used in this mixture, but unlike the others, it is not paid for by the program. The codeine combination is a relatively new mixture known on the streets as "Loads" and "Four Doors". I am advised by medical experts that Loads are considered to be as lethal as PCP, quaaludes, and amphetamines. It is also my understanding that withdrawal from "Loads" is more dangerous and difficult than withdrawing from heroin.

Twenty deaths have been attributed to "Loads" and "Four Doors" in recent months in Los Angeles County alone. At least six of them were on the Medi-Cal program. We have determined that one of these individuals received a prescription that could be used for "Loads", shortly before the overdose.

In October of this year, 51 criminal complaints in five California counties were filed against the most flagrant violators. Just last week we completed filing an additional 31 criminal complaints for a total of 82 against Medi-Cal beneficiaries involved in the ring. Those individuals for whom complaints have been filed, together with their 300 plus associates on the program, will be issued RED Medi-Cal cards in the future. These red cards act as a flag and require providers to receive Department authorization prior to dispensing drugs or filling prescriptions.

Most of the suspects have now been arrested. During the arrest process, some of these people had weapons in or about their possession ranging from switchblades to shotguns. The ages of the suspects were from early twenties to ninety. The twenty deaths in Los Angeles County involved both young and old including a 17-year-old female and a male in his seventies. One 75-year-old male who was arrested is well known to local authorities as a drug trafficker. According to intelligence files, the individual would sit in a rocking chair on the porch of his home and would sell drugs to anyone, including small children. The community had been complaining about the drug traffic and the crackdown was well received. Approximately one-third of those charged had prior criminal records ranging from narcotic trafficking, rape and sex perversion, to armed robbery and other crimes of violence.

We are currently concluding that part of the investigation dealing with the providers associated with the "Desert Drug Ring". In fact, one of the physicians involved is being suspended this month from further participation in the program. The investigation report on this individual, along with approximately ten other providers, will be referred to the California Attorney General for review and possible criminal prosecution.

As a direct result of this case, we have received numerous additional complaints and information on similar rings from physicians, pharmacies, and the general public. From the information we now have, it appears that there are other operations -- similar to the Desert Drug Ring, but perhaps larger in scope and volume. We are currently investigating three such rings in metropolitan areas much heavier populated than Bakersfield.

In another related investigation of fraudulent drug activity, it was revealed that Medi-Cal beneficiaries located in Los Angeles County were stealing and sometimes printing prescription forms, then forging physicians names to obtain a wide variety of narcotic drugs. The suspects believed to be responsible for the scheme caused hundreds of forged prescriptions to be passed in several coastal cities within Los Angeles County. Complaints for these suspects have now been filed with the Los Angeles District Attorney. Since these people did not frequent the same pharmacies, positive identification was more difficult as the pharmacies could not recall the suspects' descriptions. Consequently, expensive and time consuming handwriting experts were called in to make the case.

Other examples of the types of Medi-Cal fraud the Department has encountered recently, include individuals that have fraudulently applied for program benefits. What many have done is to intentionally omit financial assets -- that if known would cause their disqualification. We have found all sorts of such assets hidden by beneficiaries. As we know, marijuana is rather popular these days. So far this year, we have filed criminal complaints againat at least ten individuals for not reporting their illegal marijuana crops. The dollar value of the crops has been estimated as high as ¼ of a million dollars.

We are also working cases involving the wholesaling of Medi-Cal eligibility stickers. The intention of these stickers is to control services performed by providers. Each time a provider performed a service for the beneficiary, a sticker was secured to support the basis for payment. We are investigating persons who appear to be offering cash to beneficiaries for their stickers. We suspect the stickers are then sold to providers, who in turn file fraudulent claims with the program.

Mr. **Shuttleworth**. I do appreciate this opportunity to present an overview of an ongoing investigation of medicaid fraud within the State of California. I hope the information will provide the committee with a greater understanding of program fraud and California's efforts to combat it.

Approximately two-thirds of all criminal complaints filed against Medi-Cal beneficiaries in California involve some form of drug abuse. In view of this large monetary drain from the program and the adverse consequences of drug abuse, the department has been focusing its investigative efforts in this area.

Earlier this year, the department of health services investigations branch was contacted by an informant who told us about an organized group that was acquiring narcotics under the Medi-Cal program by subterfuge and deceit. The subsequent investigation, which has been in process for nearly a year, revealed some rather startling facts.

A group of approximately 400 Medi-Cal beneficiaries were acquiring large volumes of drugs for self-consumption, for sale, or for trade for hard narcotics or weapons. The operation of this particular group was centered in Bakersfield, Calif., a relatively small California town.

The program patients would travel long distances from all over the southern part of California to work the scam. One hundred miles in 1 day was not unusual. The dollar cost to the Medi-Cal program for the 3-year period that the ring was in operation, was approximately $1½ million and involved 4 million narcotic pills with a street value of $6 million.

The drug ring operated with unusual boldness. Leaders would organize 5- to 10-car caravans of beneficiaries to visit doctors' offices for prescriptions. Then the caravan would move onto the pharmacy where in many cases the drugs were waiting to be picked up by the beneficiaries.

Sometimes the drugs were traded right in the pharmacy parking lot. Other times, they would move out to the desert or other remote locations to make exchanges.

The providers and organizers of the group were noted to drive Cadillacs, Mercedes, and other luxury vehicles. Many of the dealers and small traffickers displayed all sorts of diamonds and gold jewelry.

Program recipients were recruited in an open manner. The leaders of the drug ring moved into the community and concentrated their efforts in poor neighborhoods. They offered free narcotics, cash, and in some cases, weapons in exchange for merely using the recipients Medi-Cal health card. Many of the Medi-Cal beneficiaries were alcoholics and/or drug abusers and were easily enticed by the offer. Others were just plain poor.

State investigators, together with officers from the Los Angeles sheriff's department filmed a day's events beginning with the patients' arrival and formation at the physician's office and on to the pharmacy. And I do have a video tape of that.

The drivers of these vehicles received a cash bonus, apparently to defray the cost of their personal vehicles.

I think it is interesting to note that when any one of us usually has a prescription filled, we receive a very small bag that would fit into the hand. You will notice in the video tape that many of these people are exiting the drugstore with grocery-type bags.

In this particular case, the drugs, largely purchased with taxpayer-financed Medi-Cal money, included dalmane, valium, and seconal, and when combined with codeine, give a similar effect to heroin. Doriden is another drug commonly used in this mixture, but is not paid for by the program. The codeine combination is relatively new. On the streets it is known as loads and four doors. The four door name comes from emperim four and doriden. I am advised by medical experts that loads are considered to be as lethal as PCP and quaaludes. It is also my understanding that withdrawl from loads is more dangerous and difficult than withdrawing from heroin.

In recent months 20 deaths have been attributed to loads and four doors in Los Angeles County alone. At least six of them were on the Medi-Cal program. We have determined that at least one of these individuals received a prescription that was a basic component of loads immediately before his death.

In October of this year, 51 criminal complaints in five California counties were filed against the most flagrant violators of the ring. Just last week, we completed filing an additional 31 criminal complaints for a total of 82 against the ring members. Those individuals for whom complaints have been filed, together with their 300-plus associates on the program will be issued red Medi-Cal cards. These red Medi-Cal cards serve as a flag to physicians and pharmacists to insure that they contact the department of health in California and get prior approval before any future drugs are dispensed to these particular patients.

Most of the suspects have now been arrested. Some have already pled guilty. During the arrest process, some of these people had weapons in or about their possession ranging from switchblades to shotguns. The ages of the suspects were from their early twenties to 90. The 20 deaths in Los Angeles County involved both young and old, including a 17-year-old female and a male in his seventies. One 75-year-old male was arrested—who was arrested was well known to local authorities as a drug trafficker. According to intelligence files, he would sit in his rocking chair on his porch and sell drugs to small school children or whoever wanted it.

Approximately one-third of those charged had prior criminal records ranging from narcotic trafficking, rape/sex perversion to armed robbery and other violent crimes.

We are currently concluding the part of the investigation dealing with the providers associated with the rings. In fact, one of the physicians has already been suspended from the program.

That investigation report along with approximately 10 others on other providers is being referred to the California attorney general for possible criminal prosecution.

As a direct result of this case, we have seen numerous additional complaints concerning similar rings. And they come from physicians, pharmacies and the general public.

From the information we now have, it appears that there are other operations similar to this desert drug ring, but perhaps much larger in scope and volume. We are currently investigating three such rings in metropolitan areas much heavier populated than Bakersfield, Calif.

In another related investigation of fraudulent drug activity, it was revealed that Medi-Cal beneficiaries located in Los Angeles County were stealing and sometimes printing prescription forms, then forging physicians names to obtain a wide variety of narcotic drugs. The suspects believe to be responsible for the scheme caused hundreds of forged prescriptions to be passed in several coastal cities within Los Angeles County. The district attorney has filed complaints in a number of those cases.

Other examples of the types of Medi-Cal fraud the department has encountered recently include individuals who have fraudulently applied for program benefits in the first place. But many have done this intentionally to get financial assets. If that had been known in the beginning, these people would never have been placed on the program.

So far this year, we have filed criminal complaints against at least 10 individuals for not reporting illegal marihuana crops in California. Some of the crops have been estimated at a value of nearly a quarter of a million dollars.

We are also working cases involving the wholesaling of Medi-Cal eligibility stickers. The intention of these stickers is to control services performed by providers. And then it is included in the billing to the program. We are investigating persons who appear to be offering cash to beneficiaries for their stickers.

I expect this information would be of value to the committee. I do have a video tape that is fairly short if you would care to see it. What you will see—it is two parts. The first phase of it is at the doctor's office. The parking lot is fairly empty. You will see a number of cars arrive. You will see the doctor arrive in 20 minutes. The doctor supposedly examined 20 patients. They are out the door and on the way to the pharmacy. We used two undercover cars to video tape both of these. One was at the doctor's office and one was at the pharmacy.

I think it is important to bear in mind this is 1 day, there was one doctor and one pharmacy. In reality, this happens just about every day. There were numerous doctors and numerous pharmacies involved.

So without further ado.

[Whereupon, the video tape was shown.]

Mr. **Shuttleworth**. I think you get the idea. And, again, this is a daily occurrence. This is one isolated incident. It happened four or fives times a day like that that we know about.

I would be happy to answer any questions that you may have.

Chairman **Heinz**. Mr. Shuttleworth, Senator Dole, who is cochairing this hearing with me today, had to go to a conference. He does intend to return. But what you have just described is a very commendable undertaking by your department, the investigations branch of the Department of Health of California.

I understand that the desert drug ring may have defrauded Medi-Cal, which is about 50 percent federally paid for and 50 percent State paid for, of about $500,000. You indicated a moment ago that there are other rings, other activities like this throughout the State, and that this is not at all unique or unusual. Is that correct?

Mr. Shuttleworth. Yes, sir, it is.

Chairman Heinz. Now the Federal Government, in fact, does pay for a federally funded medicaid fraud abuse unit at the State level. I was wondering if you had any dealings with the medicaid fraud abuse unit, which is part of the Inspector General's office of HHS, in this?

Mr. Shuttleworth. We have a limited amount. It probably could be a little bit better. I believe Bob Evans is the gentleman in the western region that we work with. We do exchange information and we assist each other in a number of cases.

Chairman Heinz. Now did you have any help in this case from them?

Mr. Shuttleworth. No, sir. No. This is strictly a medicaid case which could best be handled, we believed, at the local level.

Chairman Heinz. The Inspector General's office wasn't involved in any way?

Mr. Shuttleworth. No, sir.

Chairman Heinz. You have got a situation here slightly different from the one we saw a moment ago. We had expert testimony from a provider who engaged in a myriad of fraudulent activities. What you have here is recipient fraud, aided and abetted by a doctor, provider. But, nonethless, in the first instance, the people apparently directly benefiting were recipients. Is that correct?

Mr. Shuttleworth. Well, both benefited, because as I suggested, the doctor did not really examine the patients. In the film it was obvious that he did not examine anyone.

Chairman Heinz. In terms of drugs and the sale on the street, the recipients benefited. In terms of processing claims for services not received, the doctor benefited.

Mr. Shuttleworth. That's true.

Chairman Heinz. Did the doctor receive some money for his role in this scheme?

Mr. Shuttleworth. Absolutely.

Chairman Heinz. About how much?

Mr. Shuttleworth. He would claim $20 a doctor visit times 20 people. That's $400.

Chairman Heinz. That's pretty good for an hour's work.

Mr. Shuttleworth. Absolutely. Yes, sir.

Chairman Heinz. Now you indicated that one of the doctors involved is being suspended. What about the other doctors? Have disciplinary actions been taken?

Mr. Shuttleworth. We hope we can suspend them. But first, we want to try criminal prosecution with the attorney general in California.

Chairman Heinz. Do you know if any of them are going to get jailed?

Mr. Shuttleworth. Do I know if any of these people are going to go to jail?

Chairman Heinz. Will any of them go to jail?

Mr. Shuttleworth. I doubt it.

Chairman Heinz. You doubt it?

Mr. Shuttleworth. Yes, sir. From past experience, I doubt it.

Chairman Heinz. You have it clearly for all to see, and that's one of the reasons we showed this tape, something that is as fraudy and as phoney as a $3 bill taking place right under everybody's noses, as evidenced as by these TV cameras. And those people, you think, will not go to jail. How can that be?

Mr. SHUTTLEWORTH. Some of the beneficiaries may go to jail. The ring leaders and such with prior ciminal records may well go to jail; especially, those charged with felonies. But my experience is that it is very rare for providers to ever see the inside of a jail. And if he or she does, it's usually for a very short time and it's over weekends or in the evenings or some such thing.

Chairman HEINZ. There is one last question I want to ask you before my time expires and it is this: You have apparently a fairly effective antifraud unit. Are you required by the Federal Government, for the purpose of combating medicaid, to have such a unit?

Mr. SHUTTLEWORTH. Absolutely. That's my understanding. There is a legal requirement.

Chairman HEINZ. Now has your program ever been audited or measured against criteria or performance requirements by the Inspector General's office to find out if your program is any good?

Mr. SHUTTLEWORTH. We have been audited by HHS, but I am not sure if the Inspector General was involved.

Chairman HEINZ. What about the Inspector General?

Mr. SHUTTLEWORTH. I'm not sure.

Chairman HEINZ. I would think you would know if the Inspector General's office came in and said that you are supposed to have a program; do you have one? And let's see what you are doing and see if it is any good. I gather the answer to that is really "no."

Mr. SHUTTLEWORTH. To my knowledge, I haven't heard of such an examination.

Chairman HEINZ. So it would be possible for your State to have you as head of the program but not have any program?

Mr. SHUTTLEWORTH. In essence, I assume you are correct.

Chairman HEINZ. And from what I can tell, you are doing a good job. But the other 49 States—the Inspector General's office, as we all know is supposed to crack down on this kind of thing, receives money from the Congress to have a medicaid fraud unit. There is one in your State.

Mr. SHUTTLEWORTH. Yes; there is.

Chairman HEINZ. They, as far as you can tell—we could have 49 other States where there is just a figurehead and no effective State effort.

Mr. SHUTTLEWORTH. Well, I didn't suggest that because, as I mentioned earlier, Senator, while we do cooperate with the local people, with the Inspector Generals Office in San Francisco—and perhaps just for a bit of information, I understand they only have 20 investigators to cover four or five Western States so they are thin.

Chairman HEINZ. How many? Would you repeat that, again, for the record?

Mr. SHUTTLEWORTH. It's my understanding that Bob Evans has 20 investigators for the Western States. For all of the Western States.

Chairman HEINZ. For all the Western States?

Mr. SHUTTLEWORTH. Including the State of California. Yes, sir.

Chairman HEINZ. Well, I would think that would be inadequate not only to go after the obvious fraud and abuse, but I think it would even be inadequate to have adequate cooperation with your office.

Thank you very much, Mr. Shuttleworth.

Mr. SHUTTLEWORTH. Thank you, Senator.

Chairman HEINZ. Senator Mitchell.

Senator MITCHELL. Mr. Shuttleworth, does California have a procedure for registering providers before they are eligible for reimbursement under Medi-Cal?

Mr. SHUTTLEWORTH. Yes; we do. We have an application process. It's reviewed by the internal system. We have a suspension list that's about yea thick. [Indicating.] We check with other agencies to see if the person or the organization is under any kind of investigation before provider status is granted, especially on reinstatements.

Senator MITCHELL. Do you inquire on the form whether or not the provider has a prior criminal record?

Mr. SHUTTLEWORTH. I don't believe we do.

Senator MITCHELL. Do you think that would be a useful thing to do?

Mr. SHUTTLEWORTH. Absolutely. And that has been suggested in the past. I don't know if it has been changed yet, but we have suggested that.

Senator MITCHELL. You were here when Dr. Kones testified this morning?

Mr. SHUTTLEWORTH. Yes.

Senator MITCHEL. And based upon that, do you believe that would be a useful tool—simple or useful tool—for the Federal Government to follow as well?

Mr. SHUTTLEWORTH. Absolutely.

Senator MITCHELL. Now the crimes depicted on the video tape this morning could not have occurred without provider cooperation, could they?

Mr. SHUTTLEWORTH. Yes; they could, but not to the extent that they did because we do have individuals that are printing their own prescriptions and that commit other crimes not needing physician participation.

Senator MITCHELL. But on the scale that we saw this morning.

Mr. SHUTTLEWORTH. Pretty tough to do it without the doctors involved.

Senator MITCHELL. And would say, based upon that, that the pharmacist was also involved?

Mr. SHUTTLEWORTH. We believe some pharmacists are. Whether that particular one was or not——

Senator MITCHELL. You had eight or nine people who went into the same drugstore 2 days in a row and purchased large quantities of prescription drugs.

Mr. SHUTTLEWORTH. Generally, some drugstores must be involved in, but whether this particular one was or not—it might have been a 1 day situation with that drugstore.

Senator MITCHELL. Right. I understand that. And I am not trying to get you to say a particular person was involved in the crime. But based upon your experience, the volume of criminal activity of this type occurs with the cooperation of providers both at the doctor and at the pharmacy end. Would you say that is a fair statement?

Mr. SHUTTLEWORTH. Absolutely.

Senator MITCHELL. So in order to make this type of activity more difficult, at least in the volume indicated, it's important to have effective deterrents with the providers, is it not?

Mr. SHUTTLEWORTH. Yes, sir.

Senator MITCHELL. And I was rather disturbed at your—or distressed, I should say, at your suggestion that in your experience, providers would not ever see the inside of the jail, but all of the Medi-Cal or some of the Medi-Cal recipients would. Those black gentlemen that we saw walking out of the drugstore are much more likely to go to jail than the doctor who we didn't see. Isn't that true?

Mr. SHUTTLEWORTH. Yes, sir; that's correct.

Senator MITCHELL. Do you feel it's important, as a deterrent, that people like that and like Dr. Kones and others actually serve prison sentences to serve as a deterrent to the providers so that they would know that there is some punishment involved in this process not just for those at the bottom end of the scale.

Mr. SHUTTLEWORTH. I think that's one of the few ways that the problem can be dealt with properly. As of today, most people are committing abuses and fraud against the program—I think they do so because there is so little risk of having to pay any serious penalty, other than paying the money back and being placed on probation.

Senator MITCHELL. So the only thing really is that they are losing the benefits and whatever loss of reputation is involved?

Mr. SHUTTLEWORTH. That's correct. Right.

Senator MITCHELL. Well, I wanted to say that as a former judge, I am deeply concerned. And I agree with you. That's the point I wanted to make with Dr. Kones. I can understand why it is in his interest not to go to jail.

Mr. Chairman, I appreciate Dr. Kones coming here, but it's rather clear to me that he has his own objective in mind in coming here. And I can assure you that when he goes up for sentencing, his testimony here today will be cited at great length in an effort to indicate his rehabilitation and so forth.

But I just want to say that I think it is important not only for this program, but it's important for this country that we have a system in which all persons are treated equal before the law. And that it's not just the poor or the minorities who spend their time in jail, as is too frequently the case.

Right at this very moment, someone in the United States, some person is being sent to jail for stealing $10, $50, or $25. That person is almost certainly poor, and likely a member of a minority group and not someone like Dr. Kones and some of these others. That, I think, is something we could do in this country that would greatly deter this type of activity.

Thank you, Mr. Shuttleworth.

Mr. SHUTTLEWORTH. Thank you.

Chairman HEINZ. Senator Cohen.

Senator COHEN. Mr. Shuttleworth, I notice on page 2 of your statement you said that the providers and organizers of the group were known to drive Cadillacs, Mercedes, and other luxury vehicles. And that many of the dealers and smaller traffickers displayed all sorts of diamonds and gold jewelry. That might take in a good part of the State of California. It must make your job very difficult. [Laughter.]

When in southern California, I don't see anything but Cadillacs, Mercedes, and other luxury vehicles.

Mr. SHUTTLEWORTH. This wasn't in Los Angeles, by the way. It was in the desert so it was unusual.

Senator COHEN. All right. How many doctors have been prosecuted since you have been in your position for abusing the medicare system?

Mr. SHUTTLEWORTH. Criminally?

Senator COHEN. Yes.

Mr. SHUTTLEWORTH. Well, criminal prosecution is handled by the attorney general, of course. And I would venture to guess in the past 2 or 3 years perhaps 40 have been prosecuted criminally.

Senator COHEN. Forty doctors?

Mr. SHUTTLEWORTH. Forty providers. It would probably involve mostly doctors and some pharmacists, laboratories, and others.

Senator COHEN. Now on the film you indicated that the same people had walked in the day before, coming out with the same size bag.

Mr. SHUTTLEWORTH. That's correct.

Senator COHEN. Where did they get that prescription from?

Mr. SHUTTLEWORTH. That came from the doctor.

Senator COHEN. Same doctor?

Mr. SHUTTLEWORTH. Yes, sir.

Senator COHEN. So he made a half hour call at the same building, same time, same place, to the same people, the same prescription, and they all walked down to the same pharmacy?

Mr. SHUTTLEWORTH. Right. One of the doctors even had a machine in his office that was plugged into a pharmacy. And all he had to do was punch out the prescription and it registered right inside the pharmacy.

Senator COHEN. And you indicated that this same doctor got $400 for that half hour of nonwork. How much did the drugs cost? How much does the taxpayer have to come up with to pay for those drugs?

Mr. SHUTTLEWORTH. Well, for the period of time it went on—this is a smaller ring. This is $1½ million stolen from the Medi-Cal program.

Senator COHEN. You know, my father has a bakery and I watch people go in and buy rolls and bread and they come out with about the same sized bag. I have never seen this take place before. People just line up and just come out with big bags like that full of drugs.

Mr. SHUTTLEWORTH. We had never seen it before, either.

Senator COHEN. I think that most of us are rather shocked to find out that the doctor is still under investigation—I would hope under very serious investigation, intensive investigation with that kind of evidence. It's almost a presumption of illegality under those circumstances.

Mr. SHUTTLEWORTH. It certainly is.

Senator **Cohen**. And I would say the same for the pharmacy as well. I don't know how many pharmacists just have the same people lining up with that kind of an order 2 days in a row. And it was probably a lot longer.

But you didn't cover any other time frame?

Mr. **Shuttleworth**. The field investigators did but they didn't put it on tape. Sometimes instead of 20 people, up to 50 people would be involved.

Senator **Cohen**. And one of the problems that we talked about earlier today is that there is very little risk of detection, little risk of prosecution, little risk of conviction, and very little risk of severe penalties. And you measure that against the amount of money involved, and we can see how we have contributed to the system that we have.

In the State of Florida, for example, they have got a very serious drug problem. It's about a $7 billion industry in the State of Florida alone. DEA, back in 1979—I think they seized and confiscated something like $25 million. Now given the odds of detection, arrest, confiscation, $25 million barely makes their budget. But $25 million out of a $7 billion industry in the State of Florida alone. Close to $50 billion nationally.

So I repeat what Senator Mitchell has touched upon and others as well; that is, we have a situation where we have a lot of incentive to commit wrong doing and very little disincentive to prevent it. And I would reiterate that the problem we have is part of our judicial system as well. How Dr. Kones could come in here and come before this committee, relaying all of the information that he did, and yet be faced with a 30-day actual jail sentence. And he will write three more books; ending up on the Donahue show saying how he was able to cheat the Federal Government.

Mr. **Shuttleworth**. That's not atypical from my experience.

Chairman **Heinz**. Thank you, Senator Cohen.

Just so the record is accurate, it is my understanding that Dr. Kones does face 10 to 15 years for the last episodes. The first episode was 30 days.

Senator **Cohen**. I believe he had a 5-year sentence, and only 30 days of that 5-year sentence was served.

Chairman **Heinz**. That's correct. Senator Baucus.

Senator **Baucus**. Thank you, Mr. Chairman.

Mr. Shuttleworth, is it fair to say that very few abuses occur without the cooperation to some degree or another of the provider?

Mr. **Shuttleworth**. Yes. Many of them do.

Senator **Baucus**. Most?

Mr. **Shuttleworth**. That's hard to say. We don't really keep statistics like that.

Senator **Baucus**. But based upon your experience and your gut feel?

Mr. **Shuttleworth**. Sure. We have 3 million beneficiaries on the program in California, and 100,000 providers. Every month, we get somewhere between 1,500 and 2,000 complaints on both providers and beneficiaries.

Senator **Baucus**. Could you more precisely explain why it is that so many providers get off?

Mr. **Shuttleworth**. I can't answer that, Senator.

Senator BAUCUS. You must have some feeling. I guess it bothers you as it does us.

Mr. SHUTTLEWORTH. They can afford better counsel. I'm sure that has a lot to do with it.

Senator BAUCUS. What about the penalties?

Mr. SHUTTLEWORTH. Their standing in the community has a lot of influence on that factor.

Senator BAUCUS. Do you know whether the general statutes allow for a long enough prison sentence?

Mr. SHUTTLEWORTH. Oh, I think the statutes are fine the way they are. If the law provides for a 5-year sentence, but it is suspended by the court, I think that's where the problem comes in.

Senator BAUCUS. Is there a problem in overlap and interface between various agencies as between perhaps Medi-Cal and the U.S. Attorney General's office in California? Or at the Federal level between medicaid and medicare? And then the U.S. Attorney's office and Justice and the others? Is that part of the problem?

Mr. SHUTTLEWORTH. No. I don't believe that's part of the problem. I just referred a case, by the way, to the Inspector General's office in San Francisco. And he thought it was good enough and had enough attraction for the FBI. I understand last week the Inspector General referred it on to the FBI because the FBI could better handle that kind of case.

So we are discussing the cases and exchanging information on an ongoing basis.

Senator BAUCUS. So you are saying that better counsel is one of the reasons why doctor's get off.

Mr. SHUTTLEWORTH. Their counsel and, of course, their standing in the community. I would say that perhaps in a remote location, maybe he's the only doctor in town. And depending on the nature of the offense, perhaps the court would believe if we lose this doctor we won't have one. And something is better than nothing, dependent on the circumstances.

Senator BAUCUS. How widespread is this fraud in California?

Mr. SHUTTLEWORTH. That's a good question, Senator. I would hate to estimate it. I could honestly say it's in the millions of dollars.

Senator BAUCUS. Millions of dollars in Medi-Cal alone.

Mr. SHUTTLEWORTH. Absolutely. No doubt about it.

Senator BAUCUS. Tens of millions?

Mr. SHUTTLEWORTH. Sure. Easy.

Senator BAUCUS. Hundred of millions?

Mr. SHUTTLEWORTH. Um, [Laughter.]

Couple of hundred, maybe.

Senator BAUCUS. Possibly a couple of hundred millions of dollars?

Mr. SHUTTLEWORTH. I would say a couple of hundred easy.

Senator BAUCUS. Frankly, I find it outrageous that doctors and other providers are getting off. As I am sure everyone is. And I am just groping, searching trying to find some way to put these guys and gals in jail. And whether it takes stronger prosecutors or more personnel or whether it takes some more dollars—I don't know what it is.

I am worried along with Senator Mitchell about what Dr. Kones is trying to do here. I worry that he is going to come here and the foundation will be laid and the judge will say, well, he is trying to help out and reform. And then we will have a situation where another provider who is ripping the Government off is getting off. And people see that in maybe 3 or 4 months he is going to get off. And I frankly hope that the judge looks very strongly at the deterrent effect when trying to decide what sentence to impose upon Dr. Kones and any others who attempt to cooperate. I think there is too much plea bargaining around here. And too many people get off.

And you are right. It is a societal preference, unfortunately still, to certain people who are established and who have reputations in certain communities. And I find it outrageous, and I just hope that all of us quit that immediately or we are going to find ourselves in here with not one Dr. Kones, but many.

Chairman HEINZ. Senator Baucus, thank you. Senator Pryor.

Senator PRYOR. Do you think that the States can do a better job in policing this whole situation than the Federal Government?

Mr. SHUTTLEWORTH. I am biased, of course. But perhaps they can simply because the States are closer at the local level. They may have better contacts with local police. Most of my investigators are ex-policemen from somewhere in California so they know the ins and outs of the system perhaps better than someone at the Federal level.

State investigators live in remote areas as well as larger cities. Places even more remote than Bakersfield. So they are familiar with people on the streets and others that can furnish good information. I think they can acquire information easier.

Senator PRYOR. Do you feel the impact of the Inspector General of the Department of HHS in your daily activities?.

Mr. SHUTTLEWORTH. Not routinely. No, Senator.

Senator PRYOR. Are you saying that they are not totally committed nor involved to the extent that they should be in your particular State of California?

Mr. SHUTTLEWORTH. No. Not at all. As I suggested earlier, it is my understanding that the IG on the west coast has 20 investigators. I am sure that keeps the IG very busy out there. And between exchanging information and perhaps a case now and then that relates to one or the other, we have the same problem. We have something like 40 or 50 investigators to handle 20,000 complaints every year. And it's a big job.

Senator PRYOR. I am just giving you a hypothetical situation. I am not an advocate, necessarily, of this position. But if we say abolished the office of the Inspector General of HHS, and gave all the money to the States to police this horrid situation that we are faced with today, how would this impact on the problem?

Mr. SHUTTLEWORTH. I don't think I really can answer that fairly because I'm not that familiar with the IG's accomplishments, and the real mode of their operation. I don't have the information about all the cases they have worked, and why their accomplishments is such as it is.

Senator PRYOR. Is there any degree of frustration among you and your colleagues around the country that occupies similar positions with—it has been called not only a "bureaucracy" in the Inspector General's office but in addition to that lack of cooperation or lack of will by the Department of Justice in prosecuting cases.

Mr. SHUTTLEWORTH. I am not familiar with problems such as that at all. We have not really had that kind of an ongoing contact with them so I really cannot say from a day to day working relationship Senator.

Senator PRYOR. Thank you, Mr. Chairman.

Chairman HEINZ. Senator Chiles.

Senator CHILES. Can you tell us, Mr. Shuttleworth, in the cases that you are looking at with the medical providers or the doctors—are there a lot of instances where these doctors also own an interest in the pharmacy or in the drugstore?

Mr. SHUTTLEWORTH. We believe they do in certain cases. Yes, sir.

Senator CHILES. You are not able to tell what percentage of cases or anything like that?

Mr. SHUTTLEWORTH. Well, sometimes, the doctor will own the pharmacy outright, Sometimes there will be a partner or some such thing. But it does vary from case to case.

In the particular situation that you saw on the tape, I don't believe the physician had any direct relationship with the pharmacy.

Senator CHILES. That's all.

Chairman HEINZ. Mr. Chairman, I would just make one observation unless you have any questions. We saw people coming out with shopping bags full of very lethal medication. They would go into the same pharmacy or another pharmacy everyday, as I understand it, and fill up a shopping bag and walk out. Enough medication in a week, I suppose, to kill hundreds of people. As you mentioned, 41 people who, in fact, did die.

Mr. SHUTTLEWORTH. Twenty people.

Chairman HEINZ. Twenty people. Excuse me. Now an observer such as the investigator who is standing outside would clearly notice that something was afoot here. But I understand that the way you found out about this was through an informant in the drug ring itself. These individual recipients were taking huge amounts of drugs out of a pharmacy and were never noticed by the actual payment agency, Medi-Cal, itself. We all know there are supposed to be computers that look at the records of either individual providers or individual patients. How is it possible that the actual agency itself, in this case, the Medi-Cal agency—I'm sure it's also true in medicare—didn't notice?

Mr. SHUTTLEWORTH. Well, one of the reasons is that these people "doctor shop" as we call it. They don't always go to that same doctor. The next day they may go to a different one.

Our computer system in California has something like 600 or 700 edits and audits. Everytime a bill comes through, that bill is subject to these audits and edits. And everytime we add 10 more audits and edits, the providers that are abusing the program along with the beneficiaries find a way to circumvent the way the system is operating so we go back and add 10 more.

Chairman HEINZ. Well, I hear what you are saying. The time is short. But I don't really understand how it is possible that we couldn't design a system to tell us when someone is daily getting enough medication to probably kill everyone on the block. Why can't we tell that from these sophisticated processing systems that we have. That just seems incredible in this day and age of modern information management techniques. People never fail to get billed these days. If they are $2.26 overdrawn on their checking account, they get a nasty notice from somebody. It's amazing we cannot generate a nasty notice within Government for someone who is cheating.

Thank you, Mr. Shuttleworth.

[Following letters and material supplied by Mr. Charles H. Shuttleworth:]

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY EDMUND G. BROWN JR., Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814

November 25, 1981

Bill Halamandaris
United States Senate
Special Committee on Aging
G 233
Washington, D.C. 20510

Dear Bill:

This is pursuant to our recent telephone conversations regarding the "Desert Drug Ring" case associated with the Medi-Cal program.

At your request, I am enclosing the Department's news release and examples of the press coverage relating to the investigation. This data fairly well presents the "big picture" of the case. In addition, the following are facts which may be of interest to you.

The twenty related deaths occurring in Los Angeles County involved persons from 17 to 74 years old. The ethnicity of the approximate 400 Medi-Cal beneficiaries was largely black, males and females, ranging in age from early 20's to 90 years. After the arrests, it was learned that one of the individuals, a 75-year old male, who used a cane to assist him in walking, is known to police as a major drug trafficker. According to intelligence files, the individual would sit on the porch of his house while in a rocking chair, and would sell drugs to anyone, including small school children. A minister and his wife were also included in those arrested as major pusher/drivers. During some of the arrests, knives, handguns, and shotguns were found on or about the suspects.

In addition to facing criminal charges, all of those arrested will be issued "red" Medi-Cal cards, which will require providers to receive authorization prior to rendering service to such individuals. This enables the Department to reduce the risk of subsequent fraud by the same individuals.

We are continuing our investigation of other beneficiaries and suspected providers at this time. As you requested, I will keep you informed of the Department's progress in this area. In the meantime, if we can further assist you please let me know.

Sincerely,

C. H. Shuttleworth

C. H. Shuttleworth, Chief
Investigations Branch

Attachments

cc: Beverlee A. Myers
Director

The Bakersfield Californian
Newspaper "IT'S ALL HERE" Friday, November 6, 1981

16 arrested, 7 sought in drug probe

By STEVE E. SWENSON
Legal Affairs Writer

In an effort to cut down on sales of a dangerous heroin substitute in southeast Bakersfield, 16 middle-aged and elderly men and women were arrested Thursday by Bakersfield police vice officers and state Medi-Cal fraud investigators.

Officers still are looking for seven people who couldn't be found during the early-morning sweep of the Lakeview Avenue district, Bakersfield police Lt. Cliff O'Rear said.

The arrests followed a yearlong investigation and "made a helluva cut in the dangerous drug market in the community," O'Rear declared. "The black people have been complaining about these drugs."

Arrest warrants allege the suspects used fraud and deceit to obtain prescriptions for such drugs as codeine, Ritalin, Dalmane, Valium and Seconal.

Codeine and any of the other drugs can be mixed to into a "super load" that gives a user a heroin-type high at much less cost, O'Rear said.

For example, a spoonful of heroin costs $75 to $100 whereas an equal dose of the pills may only cost $10, he said.

However, there have been an increasing number of overdoses in Kern County by "super load" users, O'Rear said, and state investigators have noted that 20 people

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J.C. Scott, 54, left, suspected of fraudulently obtaining prescription drugs, was one of 16 middle-aged or older persons arrested in a sweep of the Lakeview Avenue area by police vice officers and Medi-Cal fraud investigators Thursday morning. Scott is being led to the booking desk by officer Kyle Beckman.

Staff Photo by Liz Snyder

16 arrested, 7 sought in drug probe

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ave died from the potent drug in Los Angeles County.

O'Rear confirmed that some of those arrested simultaneously obtained the same prescription from more than one doctor by hiding the act they were going to other physicians.

Prescriptions were obtained from at least three Bakersfield doctors and one Lancaster doctor, according to investigation reports in West Kern Municipal Court on three persons for whom officers had warrants Thursday.

All the doctors told Medi-Cal fraud investigators that they didn't know their patients were receiving the same drugs elsewhere.

One of those arrested Thursday, Willie Milton Byers, 55, 2010 Virginia St., went to two doctors — Dr. Samuel Schreiber, 2028 Eye St., and Dr. Azeez Bacchus of Lancaster — during a 15-month period when he bought about 2,200 codeine pills, 700 Dalmane pills and 840 Valium pills, court records say.

Police still are looking for Sammie Kennedy, 60, 1200 9th St., who during a 15-month period bought about 2,400 codeine pills, 500 Dalmane pills, 2,200 Valium pills and 440 Seconal pills primarily from Dr. Bacchus and Dr. Wilbur Butler, 2145 Niles St., according to court reports.

Another suspect still unapprehended is Harold J. Byrd, 66, 335 Lakeview Ave., who during a 14-month period bought 1,700 codeine pills, 300 Dalmane and 840 Valium from Drs. Schreiber and Bacchus, according to court reports.

Those arrested Thursday include:

[illegible] Johnetter, 39, 1005A Cannon St.; J.C. Scott, 54, and Queen Esther Scott, 54, both of 1310 E. 9th St.; Dora Lee Williams, 56, 1201 Cottonwood Road, Lillard James Gibbs, 54, 1812 Fibson St.

Lottie Olson, 82, 3608 Shellmacher Road; Trudi Lee Morrison, 46, 652 Chester Place; Iva May Byers, 54, 335 Lakeview Ave.; Charity Johnson, 80, 210 Hayes St., Henry Morrison, 67, 925 Chester Lane.

John Lillard Gibbs, 75, 1812 Fibson St.; Ben Scott Jr., 49, 1201 Cottonwood Road; Mack Davis, 52, 1110 Dolores St.; and L.B. Ray, 45, 812 South St.

O'Rear said that a majority of those arrested have been "very cooperative" in the continuing investigation by police and Medi-Cal fraud

Late Racing — Los Angeles Times — Morning Final

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Drug Rings Rip Off Medi-Cal

51 Accused of Fraud in Narcotics Sale Scheme

By DOUGLAS SHUIT, *Times Staff Writer*

SACRAMENTO—Fifty-one criminal complaints have been filed so far in an investigation of Medi-Cal recipients suspected of fraudulently obtaining drugs, which then were sold on the streets sometimes in lethal mixtures for an estimated $1.2 million a year.

Investigators for the state Department of Health Services said Thursday the scheme operated so boldly that one drug ring put together 5- or 10-car caravans of Medi-Cal recipients to tour doctors' offices and obtain prescriptions. The caravans then went on to pharmacies, where the prescriptions were filled and waiting because the doctors involved had called in advance.

The drugs were often sold or traded at the pharmacy parking lot, the investigators said.

The initial 51 complaints have been filed against rings operating in five counties: Los Angeles, Orange, Kern, Kings and Fresno. None of them were filed against doctors or pharmacists, though investigators said a number of providers were under investigation and charges could result.

Medical Experts

The drug traffickers obtained a variety of prescription drugs that were combined with codeine to produce a sometimes lethal drug mixture known on the street as "loads" or "four doors."

Loads are considered by drug control officials and medical experts to be as deadly as PCP and such widely abused substances as quaaludes and amphetamines.

In Los Angeles County alone, 20 deaths have been attributed to the use of loads. At least six of them were Medi-Cal recipients, and investigators believe the drugs leading to their deaths were paid for by the taxpayer-supported Medi-Cal program.

The scheme under investigation involved the alleged illegal trafficking of up to 1.5 million pills a year that were dispensed free to Medi-Cal patients. The investigation is continuing, and at least 46 more criminal complaints are expected to be filed by the end of October.

Overall, about 400 people are suspected to be involved, but complaints are being sought only against 100 of the worst cases, officials said.

400 People Suspected

Charles Shuttleworth, the state's lead investigator, said the drug caravans would unload as many as 30 to 40 Medi-Cal recipients at a stop. In one case, he said, 20 recipients went through a doctor's office in a combined total of 40 minutes, an average office visit of two minutes a patient.

"They'd go in with the right symptoms for the pills they wanted," Shuttleworth said. "They'd be programmed to say the right things to the doctors."

The actual cost of the pills involved was estimated at $200,000 a year, though officials estimated the street value of the drugs at six times that amount.

Shuttleworth said the rings were headed by drug dealers with prior criminal records, who were observed carrying weapons.

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os Angeles Times

EDI-CAL: Scheme to Get Drugs

ontinued from First Page

The dealers, who were not Medi-Cal recipients themselves, organized groups of Medi-Cal beneficiaries by romising them free loads or other drugs, such as he-in, or by offering to buy the prescription drugs out-ht.

Investigators said most of the drugs were obtained with the written or verbal approval of licensed physicians, though in many cases the Medi-Cal patients stole blank prescription forms or had fictitious ones printed, then forged the signature of a doctor.

Beverlee Myers, director of the Department of Health Services, said the investigation will be expanded into other counties "as time and manpower permit."

"I believe the illegal activities uncovered in this particular investigation are by no means isolated incidents," she said.

The state health services investigators were assisted in the probe by investigators from the Los Angeles County Sheriff's Department, the Bakersfield Police Department, the state Board of Medical Quality Assurance and the state Bureau of Narcotics.

DEPARTMENT OF
HEALTH SERVICES
714 P STREET, SACRAMENTO, CA, 95814

NEWS NEWS

NUMBER: 48-81
FOR RELEASE: IMMEDIATE

DATE: October 15, 1981
CONTACT: Beverly Powell
(916) 322-2060

State Department of Health Services Director Beverlee Myers today announced that 51 criminal complaints have been filed in five counties against Medi-Cal beneficiaries for illegal drug trafficking estimated to involve more than 1.5 million pills at a cost to the Medi-Cal program of $500,000 annually. The street value of these pills is estimated at $3 million annually.

Filing of the criminal complaints by local district attorneys is the culmination of a nearly year-long investigation of more than 300 Medi-Cal beneficiaries and providers by the Department's Investigations Branch.

Investigators found that Medi-Cal beneficiaries developed a variety of illegal schemes to illegally acquire large quantities of dangerous drugs purchased with taxpayer-financed Medi-Cal monies. The drugs, including Dalmane, Valium and Seconal, when combined with codeine, give the user an effect similar to heroin. Doriden is another drug commonly used in this mixture, but unlike the others, it is not paid for by the Medi-Cal program. The codeine combination is a relatively new mixture known on the streets as "Loads" and "Four Doors."

Twenty deaths have been attributed to "Loads" and "Four Doors" in recent months in Los Angeles County alone. At least six of the deceased were Medi-Cal beneficiaries. Investigators believe that prescriptions involving the components of Loads and Four Doors, linked to the Medi-Cal beneficiary deaths, were paid for by the program.

Beneficiary prescription profiles are being examined to verify or reject the theory that they died of overdoses of drugs purchased through Medi-Cal.

State officials are concerned that this type of drug activity could lead to increased drug trafficking in the schools. Although the Medi-Cal program does not pay for such drugs as marijuana, PCP, LSD and Quaaludes, these drugs are very popular in the school system according to narcotic experts, who fear this new, potentially lethal "high" will also find its way into the schools.

According to Charles Shuttleworth, chief of the Department's Investigations Branch, the principal drug dealers and organizers have long criminal records, have been observed carrying weapons, and are considered unusually dangerous.

"The dealers would organize groups of Medi-Cal beneficiaries with the incentive of free 'Loads' for individual usage, or the beneficiary could elect to trade all or part of the prescribed dangerous drugs for heroin-china white, cocaine or other narcotics," Shuttleworth explained.

"Investigators also observed apparent trading or buying of deadly weapons during the drug dealings. Some beneficiaries openly sold the drugs.

"Frequently on a daily basis, dealers would pick up five to six beneficiaries per car and travel in caravans more than 100 miles round trip. The caravans would stop and sometimes 30 to 40 persons at a time would visit a doctor's office, be examined, and receive drug prescriptions.

"One specific surveillance showed that 20 people went through these exams in a combined total of 40 minutes, an average of two minutes per patient per exam," Shuttleworth said.

"The caravan would then proceed to a designated pharmacy to have the prescriptions filled," he continued. "In some cases, the physician had a direct line to the pharmacy and would call ahead, enabling the pharmacist to have the prescriptions ready and waiting when the Medi-Cal beneficiaries arrived."

The trading and selling of the drugs often took place immediately afterwards in the pharmacy's parking lot. In other instances, the caravan would travel to a more remote area for the final exchange.

"Much of this activity was photographed and filmed by our Department's investigators and the Narcotics Division of the Los Angeles County Sheriff's Department during surveillance operations," Shuttleworth added.

Another facet of the investigation revealed that other individuals, some Medi-Cal beneficiaries and some not, accelerated their drug traffic activity by eliminating the need for a physician. These individuals either stole physician prescription blanks or had fictitious ones printed, then forged a physician's signature to get whatever drugs desired.

On the street "Loads" sell for between $10 and $20. They produce an effect similar to that produced by heroin, at nowhere near the cost. Department investigative intelligence data indicates that this form of drug abuse is becoming increasingly prevalent due to its cheap cost and accessibility.

In addition to the 51 criminal complaints just filed, Department of Health Services investigators have filed 89 other criminal complaints this year, 53 of which involved drug abuse. An additional 46 criminal complaints will be sought during the next 30 days to close the current investigation. Red Medi-Cal cards, alerting physicians and pharmacists to known drug abusers, will be issued to more than 300 Medi-Cal beneficiaries as a result of the overall investigation.

In announcing the legal actions taken by the Department, Director Myers said, "While the vast majority of Medi-Cal beneficiaries are not abusing the program, it is important that suspected abuses be thoroughly investigated and resolved, particularly in this era of limited public resources for public health programs.

"The Department receives a large volume of complaints alleging various forms of Medi-Cal fraud and abuse," she added. "We are currently receiving anywhere from 1200 to 1500 calls per month on our toll-free telephone complaint system run by the Investigations Branch.

"Our existing staff of 25 investigators has found that about one-third of these calls provide information worth pursuing. I believe the illegal activities uncovered in this particular investigation are by no means isolated incidents. As time and manpower permit, we anticipate similar investigations in other parts of the State."

Senator **Mitchell**. Mr. Chairman, could I make just one comment before Mr. Shuttleworth leaves because I think it is important not to leave an unfortunate implication present. Much of the questioning, myself included, involved the problem of significant punishment for providers as a deterrent. We talked about that. And we asked you for your thoughts on it. And you were very circumspect in your answers.

The problem goes beyond just the factors that you discussed, Mr. Shuttleworth. And I think it is important that they be identified since so much of the discussion was on this subject. It is really basically part of our system. And it does not lend itself to a simple solution.

Criminal punishment takes into account two facets: The nature of the crime and the nature of the offender. There is a superficial appeal to the idea that everybody who commits a specific crime ought to get the same sentence, but, in fact, any analysis of that at all would make it clear that more injustice would be perpetrated by adopting that principle than by adopting the principle we have here.

Maybe we saw here one of the reasons for this. You indicated that the Medi-Cal recipients had been indicted, but the doctor was still under investigation. Even if the doctor is prosecuted, he is very likely to be tried in a different courtroom, before a different judge, in a different city, at a different time. And, therefore, through no individual malfeasance, through no desire of anyone to let someone off, he may receive a lesser sentence for all the reasons you suggest. Judges are more reluctant to send a doctor with no prior criminal record and who had not done anything else wrong in his lifetime to jail than someone to whom all these factors don't pertain.

It's a very big problem that can't be solved here. I feel very strongly, as I said, that it's important for this program and for the whole justice system that some of those who are benefiting most—and it's clear that the doctors benefit the most. The doctor made a lot more than those fellows walking out of that drug store—be sent to jail and suffer severe punishment. It's a very complex problem and it doesn't lend itself to a simple solution.

Senator **Pryor**. Mr. Chairman, may I ask just one question?

Chairman **Dole**. Senator Pryor.

Senator **Pryor**. You may want to submit this in writing and that is fine, but for the record I think it would be good to have at least some short discussion on the nursing home situation as it relates to this particular problem that we are concerned with today.

For example, in the past the nursing home field has been a fertile ground for the poliferation of fraud. Especially, in those situations where the nursing home has a pharmacy within its confines or if the physician owns the pharmacy or has an interest in the nursing home. And in some of our past investigations we have found that this whole area is just absolutely rife with these conditions.

If you don't care to comment at this moment, perhaps you might enter for the record a discussion of some of the findings that you have had relative to nursing home problems.

Chairman **Heinz**. Senator, may I interrupt?

Senator PRYOR. Yes.

Chairman HEINZ. I just want to say that this is really just the first of a set of hearings. It is the chairman's intention to look into specifically the nursing home instances of problems. I happen to know you are deeply familiar with this because I remember when you pioneered back—it seemed like the turn of the century—at the turn of the 1970's, the first investigations into nursing homes in this country. I know you have a longstanding and very deep interest in that matter. We are going to pursue that.

Senator PRYOR. Thank you, Mr. Chairman. I commend you for the hearings in this area. I think it is certainly something we ought to look into.

Chairman DOLE. Thank you. I apologize for missing part of your—missing the movie. I had to go over to the Agriculture Committee on a very exciting mission. [Laughter.]

We appreciate your testimony and we will certainly keep in touch with you. Thank you very much. [Answers by Mr. Shutterworth to questions from Senator Dole.]

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY
EDMUND G. BROWN JR., Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814

January 7, 1982

Mr. Robert E. Lighthizer
Chief Counsel
Committee on Finance
Room 2227
Dirksen Senate Office Building
Washington D.C. 20510

Dear Mr. Lighthizer:

This is in response to Senator Dole's December 11, 1981 letter regarding the December 9, 1981 joint hearing (Finance Committee and Special Committee on Aging) of the HHS Inspector General's efforts to combat fraud, abuse and waste.

Question 1.

> "The Medicaid Management Information System (MMIS) is supposed to generate data for state medicaid agencies that identify instances of program abuse. Has that system ever provided data which identified the kind of fraud associated with the "Desert Drug Ring"?"

The Department of Health Services utilizes Surveillance and Utilization Review Subsystem (S/URS) reports produced by our MMIS in both the beneficiary and provider areas. These reports have been successfully utilized to detect potential abuse or overutilization of services. Providers or beneficiaries disclosed by these reports to be potentially abusing the program can then be reviewed to determine if actual abuse, overutilization or fraud existed.

Since March 1977 the Department of Health Services has successfully utilized S/URS reports to identify beneficiaries who have overutilized prescription services. Consequently, we have reduced program expenditures for unnecessary services, eliminated Medicaid as a source for illegal diversion of drugs obtained through the program in numerous cases, and enhanced the quality of care provided beneficiaries by helping control overutilization of drugs by a beneficiary. Since September 1981 the Department has expanded its beneficiary review program to also focus on beneficiary abuse of Medi-Cal Office Visits and Emergency Room Services.

If the beneficiary exceeds established utilization norms and there is no medical justification for the level of services received, the beneficiary is placed on "restriction". Once on restriction the beneficiary is issued a specially coded Medi-Cal card (colored red, rather than the standard white) which alerts the provider that authorization must be obtained before the provider can render non-emergency services. This restriction generally controls the beneficiary's overutilization. At the end of 1981 approximately 2,300 beneficiaries were on restricted status with an estimated cost avoidance of over $2.5 million dollars for 1981 alone.

While S/URS reports can be successful in identifying overutilization of services it is limited in its ability to identify many forms of beneficiary abuse such as the lending of Medi-Cal cards, forging of prescriptions or the formation of an organized drug ring such as the "Desert Drug Ring". Many of these forms of abuse cannot be detected through a review of claims payment information either on a pre or postpayment basis as this abuse may not be apparent through a review of claim payment information. Rather, the Department must rely upon other means of detection such as provider complaints filed by the public and other governmental units. To facilitate this reporting, the Department has established a toll-free phone number to report suspected fraud and abuse of the program. In addition to beneficiary reviews, the Department conducts a large number of reviews of potential provider abuse through reports developed by S/URS.

In the "Desert Drug" case a few of the beneficiaries involved did appear on the S/URS reports for abuse of prescription services. The majority, however, did not as they remained below our exception criteria. We believe that many of the "rings" and individuals involved in such illegal activities "test" the system to determine its current audits, edits, and standard controls.

Question 2.

> "The General Accounting Office has testified on numerous occasions concerning fraud. GAO stated that improved program controls are the best way to deal with fraud and abuse. In other words, we should be focusing our efforts on prevention.
>
> Your investigation shows the results of poor program controls. Do you have any suggestions on how proper controls could have avoided the "Desert Drug Ring" scam?"

In a program as large as the national Medicaid and California Medi-Cal programs, there is always the potential for fraud and abuse and adequate numbers of providers and beneficiaries who are willing to abuse the program. Any program control established must be weighed against its administrative feasibility given the sheer size of the program. While the State of California has one of the strongest sets of prepayment controls in the nation, no set of controls can prevent all fraud or abuse on a prepayment basis. The majority of prepayment controls must be established to facilitate the provision of necessary services or payment to the majority of beneficiaries or providers who do not commit fraud or abuse the program. If controls are made too tight for the majority the program would become excessively burdensome while at the same time the cost of administration would exceed any program savings. Additionally, there is virtually no prepayment control available which can detect when a beneficiary or provider has falsely misrepresented the facts in either their request for services or in their submission of a claim. This is not to discount prepayment controls which serve an important role, rather this is to point out they are limited by their nature. Also, there can be no control or viable systems detection methods when collusion exists between providers and beneficiaries, as was the case with the "Desert Drug Ring".

In addition to the prepayment controls the States must have the capability to aggressively identify and pursue individuals abusing the program. Government must have staff to perform these review functions and the capability to criminally prosecute individuals committing fraud and recoup payments made to providers found to be overbilling the program. If a provider or beneficiary is found to be abusing the program, extremely tight prepayment controls must be applied to that provider or beneficiary and they are so applied in California. In such cases, California requires that either claims in affected areas are approved by a Medi-Cal consultant prior to rendering the service or that the claim is submitted with greater justification for the service and is given additional medical review. In the case of beneficiaries, the affected services must be given prior authorization by a Medi-Cal consultant.

I hope these additional comments are of assistance to the Committees. If additional information is needed, please call me.

Sincerely,

C. H. Shuttleworth, Chief
Investigations Branch

cc: Bill Halamandaris (Special Committee on Aging)

I understand now that we have, because of the length of the hearing and its importance, to switch the witnesses slightly because Mr. Zerendow needs to catch an airplane. So if you will come forward. I might say while you are being seated that Donald Zerendow is the director of that National Association of Medcaid Fraud Control Units and assistant attorney general of Massachusetts.

Medicaid Fraud Control Units are a special group of State level prosecutors authorized by Congress and supplied with cases by surveillance and utilization review units.

Mr. Zerendow will speak to the particular problems of waste and abuse control at the State level, including insufficient funding for screening and detection of fraud.

STATEMENT OF DONALD ZERENDOW, DIRECTOR, NATIONAL ASSOCIATION OF MEDICAID FRAUD CONTROL UNITS AND ASSISTANT ATTORNEY GENERAL OF MASSACHUSETTS

Mr. **Zerendow**. Senator Heinz and Senator Dole, members of the committee, thank you for inviting me here today.

My name is Donald Zerendow. I am the director of the Massachusetts Medicaid Fraud Control Unit.

Since February of 1981, I have also been the president of the National Association of Medicaid Fraud Control Units.

In 1977, as you all recall, the Congress voted the enactment of Public Law 95-142, which provided incentive funding for the States to establish provider medicaid fraud control units. Two and one-half years later, the General Accounting Office conducted an audit and evaluation of the 29 units then in existence, and recommended that Federal funding be continued. They found that the fraud control units can be an effective force in combating medicaid fraud.

The units' investigations and successful prosecutions have included all provider medicaid categories as well as prosecutions for the abuse of medicaid patients in long-term care facilities.

In doing so, the units have developed a degree of expertise in this area that was unknown to the medicaid system prior to the units' creation.

As a direct result of enactment of Public Law 95-142, there exists today 29 units across the country which are, without a doubt, this Nation's best weapon to combat provider medicaid fraud.

Attached to this statement is a copy of my remarks to a legislative committee in the Commonwealth of Massachusetts which shares with you on a State level, the same concerns that you have. That statement highlights for you the parade of horribles that have been prosecuted by the Massachusetts Fraud Control Unit.

The important point to be made about that laundry list of ripoffs is that it is not unusual. It is, rather, simply representative. Any established unit in the country could appear before you and testify to remarkably similar results. Such prosecutions surely have had a significant deterrent impact but much more can and must be done to increase our effectiveness in eliminating provider medicaid fraud.

However, in order to accomplish that at the national level, the priority, attention and resolve of the Department of Health and Human Services are required. It requires a coordinated effort between HCFA and the Office of Inspector General. In addition, on a State by State basis it will require the same top priority and coordinated efforts between the units, the medicaid fraud control units, and their respective single State agencies which administer the medicaid program.

In enacting Public Law 91-142, Congress, and later the Department of Health and Human Services, deliberately excluded the screening and detection for provider fraud function from the business of the medicaid fraud control units. That responsibility remained within the single State agency. It's ability, desire and confidence to perform that function directly impacts upon the units' effectiveness. At the time, the rationale for that exclusion was apparent and even seemed reasonable.

However, in continuing that function within the single State agencies without providing increased incentives to effectively perform that task a fundamental error was made. The irony about Public Law 91-142 is that it is an irony of national proportions. Under the terms of this legislation, the eyes and the ears of the medicaid fraud control units became single State agencies. Because of their historic failure to perform the eyes and ears function, they were largely responsible for the needs to create those prosecutory entities known as medicaid fraud control units.

Every single State agency has been effectively performing that function and there has been less need for medicaid fraud control units. Thus, the units were created and their potential for full success was tied to the single State agencies' ability to do things which they had demonstrated a lamentable inability to do for many years.

It was as though the U.S. Attorney's Office was created because the FBI was not able to develop any cases to prosecute. But unlike the U.S. Attorney's Office relationship with the FBI, the fraud control units do not have coercive or authoritative power in their dealings with a single State agency or its medicaid department.

In the roughly 3 years that most units have been in existence, we have developed a strong relationship with the single State agency which now permits a frank discussion of their deficiencies and inadequacies with regard to provider fraud identification.

This is an important step forward. Although the single State agencies will now listen to and acknowledge the existence of their deficiency, there is an enormous gap between their acknowledgement and any meaningful remedial response.

One explanation for the single State agencies' inability to respond with remedial action is their hierarchy of priorities. At the top of that hierarchy is the agencies' ability to deliver and process payments for recipients and providers. That, in itself, is an enormous undertaking.

Given that responsibility, the screening and detection function for provider fraud has been made a low priority. The fraud detection function fails to receive the priority it requires from a single State agency because of the kind of the service delivery function. Considering the effects of further cutbacks on its current limited resources, I am not optimistic that the sir[illegible] State agencies will find the resources necessary to increase th[illegible]bility to fully perform the fraud detection function.

And when the single State agencies' inability to effectively perform the screening and detection functions is brought to the attention of the Health Care Financing Administration, we discover that its ability to fashion a remedy is really limited to the power of persuasion. Its only real sanction is to cut off all Federal financial participation. Such a threat is neither credible nor practical.

On a national level an aggressive leadership is now needed to overcome the present impasse. The surveillance utilization and review function of the single State agency must be assigned a high priority and effective resources by the single State agency.

In his first address to Congress, President Reagan referred to fraud and abuse as a national scandal. And on September 24, 1981, in a speech to the Nation, the President specifically referred to health care provider fraud as a special concern of his administration.

What is needed now is to fashion a program that will do for the single State agencies' fraud section what was done for the fraud control units. Both entities want the same level of priority. And the realization of the full potential of either entity is dependent upon the other's ability to perform effectively.

There are perhaps many plans that could be considered to raise the level of priorities that are now assigned. Two such plans have recently received some attention. Both plans recognize the need to provide an incentive to the States in order to make the SUR's units an attractive function.

One such approach would be to permit the States to retain, within the medicaid, 100 percent of its recoveries attributable to the SUR's units efforts in detecting fraud and abuse. The other is to fund the SUR's units the same level that the fraud control units are now funded.

Both of these approaches have their inherent problems and neither is a panacea. They are offered only as suggestions to be considered. More important than the nature of the ultimate answer is the need today to directly focus on the question and problem.

Chairman DOLE. Senator Heinz.

Chairman HEINZ. Thank you, Mr. Chairman. Mr. Zerendow, you mentioned that State units are now, without a doubt, this Nation's best weapon to combat provider medicaid fraud. And it seems to me that two fair measures of best in this case are first, finding instances of fraud and penalizing them. And then, second, preventing fraud and abuse in the first place.

Can you defend your claim according to these criteria with specific reference to the following: (1) What has been the dollar amount of recoveries through the SSCU; (2) how many convictions have the unit accounted for and what has been the longest sentence; (3) have the units been able to identify patterns of abuse that might imply a need for program reform. And if so, what mechanism is there for implementing such changes?

Mr. ZERENDOW. I don't know if I am going to keep them all in order or get them all.

Chairman HEINZ. I will give you probably some unnecessary prompting. What about the dollar amount of recoveries?

Mr. ZERENDOW. In terms of Massachusetts, in the first instance—I can speak more familiarly about Massachusetts and I can give you some number in regard to the rest of the Nation but not as definitively—in Massachusetts, we have collected through either civil fines, overpayment or court ordered restitution or referrals back to the single State agency—forceable collection in excess of $5 million. In Massachusetts, there have been 50 cases completed to conviction. There have been 61 indictments. We have opened a total of 727 cases. And at the present time, there are 205 cases pending in our office.

In terms of the rest of the country, Senator, to demonstrate that I do have some contact with the Inspector General's Office and I do know he is there and I do call upon for him assistance, I did speak to his Office this morning and got these numbers from the Inspector General's Office concerning the Inspector General's efforts in monitoring the efforts of the fraud control units in the various States. And I was told by that Office that since the units have been established across the country, the units have opened up 8,097 cases. They have returned 762 indictments. And there have been 525 convictions. And there has been a total amount of—as I have written here—overpayment fines and restitution of $57,158,782.

Chairman **Heinz**. Thank you. What about—you mentioned convictions. What about the program reform?

Mr. **Zerendow**. Again, I can speak perhaps best for Massachusetts. I can't tell you what other fraud control units have done. But I can say in general they follow the very similar kind of pattern in terms of making recommendations. In Massachusetts, when we started our business, we noticed that we had some peculiar statutes that didn't seem to address the crime of medicaid fraud. We had the common law larceny statute which, as a prosecutor, makes your burden of proof much, much more difficult. You not only have to prove the false statement, but you have to prove that someone relied on that false statement. And as a result of that reliance, they parted with some money. And then I have to prove how much money was parted with. And I have to prove every check, every payment.

When we entered business in Massachusetts, we discovered there was no medicaid false claims act. We created the—we recommended one be passed. It was enacted last year. And it now makes the very utterance of the false representation a 5-year felony and a $10,000 fine. Previously, under larceny it was a $600 fine. And in those circumstances, a maximum of 2½ years.

In addition to the direct approach with medicaid fraud statute, we have also introduced legislation to cure what we thought was a defect in the State's law. And that was to address patient abuse as a specific crime. Prior to the enactment of that statute in Massachusetts, there was only the general assault and battery type of a law. And we created a patient abuse statute.

In terms of the rest of the fraud control units, my best information is that several States—and I think I can tell you several States have enacted very similar legislation. And if you would like, they are: Louisiana, Michigan, Montana, Virginia, Ohio, West Virginia, California. And that list does not pretend to be exhausted. I just had that piece of information with me.

Chairman **Dole**. Senator Mitchell.

Senator MITCHELL. Mr. Zerendow, you commented on the exclusion of screening and detection of provider fraud in the business of the fraud control units. You said that sometimes the "rationale" was apparent and seemed reasonable. And then you made some recommendations at the end of your statement which really would continue that present structural framework.

I want to ask you two questions. What was the rationale? And is it still reasonable in your judgment or is not a third alternative suggestion to end the exclusion?

Mr. ZERENDOW. I don't know if the word "rationale" was appropriately chosen. I think perhaps what I meant to say was that it was never thought about. That perhaps the idea as to the consideration as to whether or not the SUR's units were, in fact, performing as Congress expected them to have been performing for several years was ever really considered.

If it were considered, however, I think Congress probably would have assumed that they had been paid 50 percent reimbursement for the last 12 years in 1977—so they probably would have assumed that they are doing that function, why should we pay the fraud control units that amount of money to do that and duplicate what we are already being paid for.

I think it took us not too much longer after we became established to begin to feel that the function wasn't being performed. And it was about 2½ years after we got going that the Inspector General's Office recognized that there were some things lacking in regard to fraud referral from the single State agencies. And permitted the units to begin to do their own kinds of identification. The problem with that is that there were no real resources added to our ability to do that.

Senator MITCHELL. Well, let me ask you, do you agree—you were here all morning?

Mr. ZERENDOW. Yes, sir.

Senator MITCHELL. You heard the discussion about the problems of provider fraud. Do you agree that that's a very important element of the whole attempt to reduce fraud and abuse? And that is to have a very meaningful and effective detection, prosecution, and punishment of those providers engaged in fraud?

Mr. ZERENDOW. Everyone of those steps.

Senator MITCHELL. Everyone of them?

Mr. ZERENDOW. Right.

Senator MITCHELL. And, therefore, would you recommend that the exclusion to which you refer no longer pertains and that the detection of provider fraud be included as part of the function of the fraud control units?

Mr. ZERENDOW. I don't know that I am ready to say all of that right now because as I understand that function, it would require an enormous amount of resources to be put into the hands of the fraud control units. It would require enormous hardware of computer programs.

But what I would certainly suggest is that that is a possible way to go. It is worth considering. It's worth thinking about. It's worth talking about. It's worth saying what is right and what is wrong with that approach and deciding it ultimately. I don't think I have completely thought it through, but it's one way.

Senator MITCHELL. Well, my time is up, but I just want to say that from my standpoint, I think that effective prosecution and punishment of provider fraud is a very important, if not the most important part of the problem. Not only for the program itself, but you are a lawyer; you prosecute cases. And I am sure you probably have sent some very poor people to jail and then chagrined to see someone engaging in a larger crime be put on probation. It happens all the time; we all know it.

If you are not prepared to say that now, would you give that some thought, and let us have your specific recommendations in writing. A yes or no or some other recommendation because I think it's important that we get to that part of the problem and in an effective manner.

Mr. ZERENDOW. Yes, sir.

[The information was subsequently supplied by Mr. Zerendow:]

[illegible]

State Agency (Name of State) ______________________

State Fraud Unit (Name of State) ______________________

OPI Regional Office/Office of Investigation (Name) ______________________

Medicare ☐ Medicaid ☐ Carrier/Intermediary Name ______________
Carrier/Intermediary Number ______________

Date Received: ______________ Date Investigation Initiated: ______________
Date Referred to Fraud Unit, OI or Other: ______________

Suspect Individual or Organization

A

Name ______________ Case Number ______________
Street Address ______________ City, State ______________
(Cross Reference Name) ______________ Case Number ______________
Street Address ______________ City, State ______________

Classification of Suspect Circle One

B

01 MD
02 DO
03 Podiatrist
04 Dentist
05 Hospital
06 SNF
07 HHA
08 Therapist
09 Clinic
10 DME
11 Laboratory
12 Ambulance
13 Drug Supplier
14 Renal Facility
15 Chiropractor
16 Optometrist
17 ICF
18 Transportation Co.
19 Recipient/Beneficiary
99 Other Explain ______________

Nature of Potential Fraud Complaint Circle One

C

01 Billing for Services Not Rendered
02 Misrepresenting Services
03 Altering of Bill/Receipt
04 Duplicate Billing
05 Falsifying Records/Documents
06 Kickback/Rebates
07 Eligibility
08 Embezzlement
09 Solicitation of Donations
10 Forgery of Check
11 Certification Fraud
12 Overcharging
13 Prescription Splitting
14 Generic Substitution
15 Breach of Fiduciary Relationship
16 Physical Abuse, Neglect
17 Fraudulent Cost Reports Specify ______________
99 Other, Explain ______________

Source of Complaint Circle One

D

01 Recipient/ Beneficiary (Direct)
02 Medicare Bureau
03 Medicaid Bureau
04 Media
05 Public Assistance Agency ______________
06 Social Security Office ______________
07 Intermediary
08 Carrier
09 PSRO
10 Other Governmental Source
11 State Agency
12 OPI RO
99 Other, Explain ______________

Action Resulting From Investigation

E

		Date
01	Closed No Criminal Fraud	______
02	Referred to Federal Prosecutor	______
03	Referred to State Prosecutor	______
99	Other ______	______
04	Referred to Local Prosecutor	______
05	Referred for Administrative Action	______
	Overpayment Amount Determined $ ______	

Indictment or Filing of Criminal Information

F

01 Indictment or Filing of Criminal Information (Date) ______________

Criminal Fraud Disposition

G

		Date
01	Prosecution Declined	______
02	Grand Jury - No Bill	______
03	Nol Pros/Dismissal	______
04	Acquittal	______
05	Pretrial Diversion	______
99	Other ______	
06	Conviction (Forward Copy to CO)	______
07	Restitution	$ ______
08	Fines/Penalties	$ ______
09	Out of Court Settlement	$ ______

Civil Action

H

01 Civil Action N/A ______________
02 Civil Action Initiated ______________
03 Declined ______________
04 Judgment in Favor of Vendor ______________
05 Judgment Against Vendor ______________
06 Fines/Penalties $ ______________
07 Restitution Ordered $ ______________
08 Negotiated Settlement $ ______________

Chairman DOLE. Senator Cohen.

Senator COHEN. A couple of comments, Mr. Chairman. Last year, we had those investigations into the chop-shops; we had a professional car thief come before the committee and demonstrate in living color how you break into a car in less than 30 seconds. I had that exact tool used on my car recently in New York. [Laughter.]

I'm not sure it was the same fellow or not. But what it brought to mind was—what happened is that my radio and other things were taken from the car. The police weren't terribly interested in going after whoever was responsible for it. I filed a claim with the insurance company and the insurance company paid me. And 4 months later I received a new radio. And the rate, of course, for everybody else in the country goes up. And what you have, in essence, is the socialization of crime in this country where we kind of just spread the risk throughout the country. And the rates keep just going up with everybody paying a higher burden.

It seems to me that we have similar mind set—again, I come back to an attitudinal problem—in our health care programs. When I held up this diagram before when we had our hearings, we had the Federal Treasury with all these dollar signs here; we have the HCFA, Health Care Financing Adminstration; we had the fiscal intermediaries with Blue Cross and Blue Shield; then we had the not-for-profit agencies; then we had the subcontractors. And the money was flowing through this entire scheme. And there are no checks along the way. There is nobody checking the figures that are submitted or those costs.

The reason I raised this is because you indicated in your statement that unless we have some change in priorities and money to deal with verifying the rate setting, we are never going to come to grips with this particular problem.

We heard Dr. Kones here this morning saying that he submitted outrageous things almost hoping to be caught. Look at some of the things you have talked about here that have been included for reimbursement out of this big Federal Treasury with the dollar signs: Expenses for travel vacation, expenses for summer house rentals, expenses for painting in the private residences, camera equipment, stonewall masonry done at residences, expenses for rock removal from farm fields, expenses for the removal of dead trees and diseased dutch elm from the residences—and it goes on and on and on for three pages listing things that are included for medicare reimbursement. And nobody is checking up on this. They are sitting at a desk; they are cutting back on audits.

And one of the real ironies—even in our own administration, Mr. Chairman—is that when we have evidence of the kind of lack of audit, lack of oversight, we are cutting back at the Federal level in our audit programs. I think this gentleman who is testifying is absolutely right. Unless we make some fundamental changes in our priorities and put the money there, we are going to be back here in 2 or 3 years with the same sort of hearing with the same sort of attendance and the same sort of cameras repeating the same things.

Chairman DOLE. Thank you, Senator Cohen. Senator Pryor.

Senator PRYOR. No questions.

Chairman Dole. Mr. Zerendow, you have got about 45 minutes to catch your plane so let me just thank you for being here. I would like to ask one question because it touches on the point made by Senator Cohen.

Of course, you mentioned that we need to give the medicaid State agencies greater incentives to assure that their surveillance and utilization review units are viable and have a high priority. And I don't disagree with that. As a part of the recent reconciliation bill, Federal matching payments to States are being reduced by 3 percent for fiscal year 1982, 4 percent in 1983, and 4½ percent in 1984. Under that same legislation, the State could lower by 1 percent the amount of its reduction bv demonstrating 1 percent recoveries from fraud and abuse.

Do you think this is going to provide a considerable incentive for improved State performance or not?

Mr. Zerendow. No. Absolutely not. If it is anything, it's a negative incentive. I don't know how that law is going to be interpreted or regulated by the agencies responsible for it, but I do understand that one approach to interpreting that law is to suggest or say or regulate to the single State agency and say to the single State agency, "Yeah. That's right. You can get back 1 percent of what you have identified. That will put you back in the status quo where you were before we took it away." I say that is no way good enough.

But one approach to regulate and define how you get back that 1 percent is to say to the single State agency that we are only going to let you count the money that you get back as a result of nonroutine audits. In other words, extraordinary audits. Something over and above that you were doing before we took your 1 percent away.

Chairman Dole. Thank you, Mr. Zerendow. We have no further questions at this time, but would ask you to answer some questions for the record.

[The information follows.]

Question 1. Is there a mechanism available to exchange information between state medicaid fraud control units about program abusers and various scam operations? Is similar information provided to the Health Care Financing Administration or the Office of Inspector General on a regular basis?

Answer. With regard to providing Fraud Unit information to the Health Care Financing Administration and the Office of the Inspector General: The Units are required by regulation to report to the Health Care Financing Administration the opening of each investigation of a medicaid provider. This information is supplied to the Health Care Financing Administration on a form entitled a "Health Care Financing Administration #50" and is updated in accord with the action codes contained therein. The Office of Inspector General is given access to this information by the Health Care Financing Administration. A copy of this form is attached.

The Units themselves exchange information about program abusers and various scam operations through at least three established mechanisms. The Units in the Association are broken down into five Regions; each of these regions hold regional training conferences at least once a year. In addition, there is an Annual Medicaid Fraud Control Unit Conference for all Units. This year's Conference was held in Boston the week of December 7-11, 1981. The Executive Committee of the Association representing all the regions also meets independently of the training conference to discuss such information sharing. And finally, the Association has contracted with the National Association of Attorneys General to act as a central clearing house for collecting and disseminating such information to the Units. The National Association of Attorneys General also publishes and distributes to the Units and other interested parties a monthly "Medicaid Fraud Report."

Question 2. Does the National Association of Medicaid Fraud Control Units have any data on the cost of the State units versus amounts MFCU's recover?

Answer. The National Association of Medicaid Fraud Control Units does not maintain current statistics concerning this question. The Office of Inspector General of Health and Human Services does; accordingly I have requested that office to respond.

ANSWER PROVIDED BY THE OFFICE OF INSPECTOR GENERAL

Quarterly information regarding fines, overpayments and restitutions is provided by the Medicaid Fraud Control Units to the Office of Inspector General. The Inspector General's office also maintains records of the Federal share of expenditures charged to this grant by the Units.

Non-monetary benefits, such as improved health care, deterrence of fruad committed by Medicaid providers and more effective and efficient administration of the Medicaid program through improved regulations and policies are perhaps more benefitical than monetary recoveries.

Fiscal Year 1981:	*Millions*
Fines, overpayments, and restitutions reported	$36.1
Federal share of expenditures	27.9

We do appreciate your testimony. We will hope that you will be able to cooperate with our staff. Thank you very much.

Mr. ZERENDOW. Thank you.

[The prepared statement of Donald P. Zerendow follows:]

STATEMENT OF

DONALD P. ZERENDOW, CHIEF

MASSACHUSETTS MEDICAID FRAUD CONTROL UNIT

December 9, 1981

Mr. Chairman and members of this Committee, I want to thank you for permitting me this opportunity to express to you my thoughts and concerns. My name is Donald P. Zerendow. I am the Director of the Massachusetts Medicaid Fraud Control Unit, and I have held that position since the Unit's federally subsidized establishment in August of 1978. Since February of 1981, I have also held the position of President of the National Association of Medicaid Fraud Control Units.

In 1977, the Congress voted the enactment of P.L. 95-142 which provided the incentive funding for the states to establish provider Medicaid Fraud Control Units. Two and one half years later, the General Accounting Office conducted an audit and evaluation of the 29 Units then in existence. Its report issued on October 6, 1980, recommended continued federal funding and concluded that the ... "fraud control units can be an effective force in combating fraud." P.7.

The Units' investigations and successful prosecutions have included all Medicaid provider categories as well as prosecutions for the abuse of medicaid patients in long-term care facilities. In so doing, the Units have developed a degree of expertise in this area that was unknown to the Medicaid system prior to the Units' creation.

As a direct result of the enactment of P.L. 95-142, there exists today thirty Units across the country which, without a doubt, are this nation's best weapon to combat provider Medicaid fraud.

Attached to this statement is a copy of my remarks to a legislative committee in Massachusetts which shares on a state level the same concerns as you. That statement highlights for you the parade of horribles that have been prosecuted by the Massachusetts Fraud Control Unit. The important point to be made about that laundry list of ripoffs is that it is not unusual. It is, rather simply representative. Any established Unit in the country could appear before you and testify to remarkably similar results.

Such prosecutions, surely have a significant deterrent impact, but much, much more can and must be done to increase our effectiveness in eliminating provider Medicaid fraud.

However, in order to accomplish this on a national level, the priority, attention, and reaffirmed resolve of the Congress and the Department of Health and Human Services are required. It requires a coordinated effort between the H.C.F.A. and the Office of the Inspector General; in addition, on a state by state basis, it will require the same top priority and coordinated effort between the Units and their respective Single State Agencies.

In enacting P.L. 95-142, Congress, and later the Department of Health and Human Services, deliberately excluded the screening and detection of provider fraud function from the business of the Medicaid Fraud Control Units.

That responsibility remained within the Single State Agency. Its ability, desire and competence to perform that function directly impacts upon Units' effectiveness. At the time the rationale for that exclusion was apparent and even seemingly reasonable. However, in continuing that function within the Single Sate Agencies without providing increased incentives to effectively perform that task a fundamental error was made.

There is an irony about enactment of P.L. 95-142 and it is an irony of national proportions. Under the terms of this legislation the eyes and ears of the Medicaid Fraud Control Units became the Single State Agencies which, because of their historic failure to perform the eyes and ears function, were largely responsible for the need to create these prosecutorial entities. Had the Single State Agencies been effectively performing that function, there may have been less need for Medicaid Fraud Control Units. Thus the Units were created and their potential for full success was tied to the Single State Agencies' ability to do things which they had demonstrated a lamentable inability to do for many years.

It was as though a United States Attorney's Office was created because the Federal Bureau of Investigation was not able to develop any cases to prosecute. But unlike the United States Attorneys Office's relationship with the Federal Bureau of Investigation, the fraud control units do not have coersive or authoritative power in their dealings with the Single State Agencies.

In the roughly three years that most Units have been in existence, we have developed a strong relationship with the Single State Agencies that permits a frank discussion of their deficiencies and inadequacies with regard to provider fraud identification. This is an important step forward. Although the Single State Agencies will now listen to and acknowledge the existence of their deficiencies, there is an enormous gap between their acknowledgment and any meaningful remedial response.

One explanation for the Single State Agencies' inability to respond with remedial action is their hierarchy of priorities. At the top of that hierarchy is the agencies' responsibility to deliver services and process payments for recipients and providers. That in itself is an enormous undertaking. Given that responsibility, the screening and detection for provider fraud function has remained a low priority.

The fraud detection function fails to receive the priority it requires from the Single State Agencies because of the primacy of of the service delivery function. Considering the effects of further cutbacks on its current limited resources, I am not optimistic that the Single State Agencies will find the resources necessary to increase their ability to fully perform the fraud detection function.

When the Single State Agencies' inability to effectively perform the screening and detection function is brought to the attention of the Health Care Financing Administration, we discover that its ability to fashion a remedy is really limited to the power of persuasion, its only real sanction to cut off all federal financial participation. Such a threat is neither credible nor practical.

On a national level an aggressive leadership is now required to overcome the present impass. The SURs function within the Single State Agency must be assigned a high priority and effective resources by the Single State Agency. In his first address to Congress, President Reagan referred to fraud and abuse as "a national scandal". And on September 24, 1981, in a speech to the Nation, the President specifically referred to health care provider fraud as a special concern of his Administration.

What is now needed is to fashion a program that will do for the SURs Units what was done for the fraud control Units. Both entities warrant the same level of priority, and the realization of the full potential of either entity is dependent upon the other's ability to perform effectively. There are perhaps many plans that could be considered to raise the level of priority that the SURs Units are now assigned. Two such plans have recently received some attention. Both plans recognize the need to provide an incentive to the states in order to make the SURs Unit an attractive, viable and high priority function within the Single State Agencies. One such approach would be to permit the states to retain within the Medicaid Program 100 percent of its recoveries attributable to the SURs Units' efforts in detecting fraud and abuse.

The other approach is to fund the SURs Units at the same level that the fraud control Units are funded. This would mean providing the SURs Units with 90 percent federal reimbursement for a period of years and 75 percent thereafter.

Both of these approaches have their inherent problems. And neither is a panacea. They are offered only as suggestions to be considered. More important than the nature of the ultimate answer is the need today to directly focus upon the question and problem.

STATEMENT OF DONALD P. ZERENDOW
CHIEF, ATTORNEY GENERAL BELLOTTI'S
MEDICAID FRAUD CONTROL UNIT

MAY 27, 1981

My name is Donald P. Zerendow. I am the head of Attorney General Bellotti's Medicaid Fraud Control Unit. The Unit became operational in October of 1978 and is headquartered at 18 Oliver Street, Boston.

Back in 1977 and in 1978, the Federal Congress undertook committee investigations into Medicaid Provider fraud. Those hearings generated newspaper headlines quite similar to that which appeared in last Saturday's Herald American. In response to the findings and conclusions made in those hearings, the Congress responded by creating a funding machanism for the states to establish Medicaid Fraud Control Units. Under the terms of this legislation, the federal government agreed to pay 90 percent of the expenses for the operation of a Medicaid Fraud Control Unit. Even prior to the Congress's acknowledgment of the need for a prosecutorial effort in the area of provider Medicaid Fraud, Attorney General Bellotti saw the great potential for provider fraud within the nursing home industry, and in 1977, he established the nursing home task force. In October of 1978, the task force began operating as the Medicaid Fraud Control Unit with the enlarged responsibility of investigating and prosecuting instances of fraud perpetrated by all categories of medicaid providers.

There are many types of providers participating in the Medicaid system but basically they can be distinguished by two generic headings: Institutional Providers (nursing homes and Hospitals) and all the others which are called Ambulatory Providers. In terms of numbers, there are many more ambulatory providers than there are nursing homes, resthomes and hospitals. The ambulatory providers include, Doctors, Dentists, Pharmacies, Psychiatrists, Laboratories, Transportation Companies, Medical Equipment Suppliers and Optometrists, and many others as well. Although in numbers, the ambulatory providers far outnumber the institutionsl ones, only approximately 20 percent of the Medicaid budget goes to pay for the legitimate services of ambulatory providers. The remainder, or roughly 80 percent, goes to the institutional providers. It is thus apparent that the bulk of the taxpayers' money goes to institutional providers to reimburse them for their costs in the delivery of quality health care to medicaid recipients.

The type of fraud perpetrated by the ambulatory and institutional provider differs greatly, and the different schemes and fact patterns are in direct response to the manner or methodology by which the state has chosen to pay for the services rendered. On the ambulatory side the state has chosen to pay on a fee for service basis. Each time a doctor sees a patient, or a dentist fills a tooth or a laboratory performs a test, or a transportation company provides a ride, each one of these providers is supposed to bill the Welfare Department for the service actually rendered. And in this fee for service relationship what happens sometimes is what every one should have expected but did not. The provider will simply bill for a service that was never performed, or as is just as often the case, he will provide a simple service and bill for the more complicated and expensive service. On the ambulatory side, the scheme is pretty simple - and basically it is billing for services not rendered. The scheme is simple but the variations are as different as the individual professional practice or his business. On the ambulatory side, we have investigated and pursued to conviction the following types of fact patterns:

- Pharmacies billing for drugs that were never dispensed and never prescribed,
- Pharmacies billing for the brand name drugs when, in fact, the generic drug was dispensed to the recipient,
- Pharmacies billing the Department of Public Welfare for more than what it charges its cash street-private paying trade for the same drug,

Physicians billing for services that were never rendered,

Physicians billing for the more expensive service when only a lesser service was rendered - as an example, a physician may see a patient at a nursing home but bill as though he saw the patient at his office,

Laboratories that have billed for tests that were neither requested by a physician nor performed by the laboratory,

A laboratory ~~that~~ gave a physician false results of a certain test because the test was never performed causing the physician to rely and treat a patient based on the false results,

Transportation companies that have billed for trips that were never made,

A taxi company that billed for over three thousand dollars in taxi rides for people who were dead at the time of the alleged ride. The same taxi company billed for over 25 thousand in one year for trips to a Methodone clinic for a patient who had not taken any of the trips in its cab, By no means is this an entire listing of our investigations and is intended only to demonstrate to you that in a fee for service system of payment, the basic scheme to defraud will be to bill for services not rendered. Another implication that I hope will not go unnoticed is that in many of the above cases, the amount actually stolen with each false invoice is relatively small. A pharmacist who bills for a brand drug yet actually dispenses the generic one, might be stealing as little as 50 cents on each false bill. The dentist who bills for the nonexistent filling might reap the benefit of a ten dollar larceny for each false billing. The same thing applies to the doctor's $15 office visit that never occurred, or the laboratory's $5.00 test that was never performed. On an invoice by invoice basis, it would appear that the ambulatory providers are nickel and diming the Medicaid system. And from my point of view, I hope you can understand some of the difficulties we have in building a larceny case that exceeds

$100. Once a provider sets up his pattern, he does it routinely and to the extent of thousands of dollars, but the problems of proof relating to hundreds and thousands of invoices is sometimes enormous, complex and very difficult. In an effort to address the real crime, Attorney General Bellotti drafted the Medicaid False Claims Act which became effective last November. Under the terms of that statute each false invoice submitted by the provider can be the basis of a conviction of a five year felony. With time and after some convictions and appropriate punishment under this statute, we expect it to operate as a viable deterrent to the growth of this sort of fee for nonservice fraud.

With regard to institutional provider fraud, the pattern of fraud is entirely different. And it is different because of the different way in which these providers are paid. The state pays nursing homes on the theory that it will reimburse the home for those reasonable costs directly attributed to the care of patients residing in the nursing home. In order to do this the state requires the nursing home to submit a cost report which is supposed to contain only those expenses and costs relating to the operation of the nursing home. In theory there may not be anything wrong with this method of payment. Some may say that all cost plus relationships are bad, but if the state does receive true and accurate information about a home's costs, then it can be a fair and equitable method of reimbursement. It may provide no incentive to keep costs down, but at least in theory the state pays only the real costs of the home plus a profit.

That is the way the reimbursement system works in theory; that is not the way the system works in reality. It does not work that way in practice because a very necessary, fundamental and basic security device to ensure the integrity of that sort of reimbursement system was never effectively put in place. At the heart of this reimbursement system is the nursing homes' cost report and the states' reliance on the truth of that cost report for setting rates. Yet for years, thousands of cost reports have been filed and for all practical purposes, the state has not been able to find the resources to conduct even the nominal number of field audits required by federal regulations. Without a regular routine of competent and intensive on-site auditing of a nursing home's books, checks, invoices, and records, it is impossible to know with any sense of reliability that the numbers on a cost report truly reflect the costs of the home and not any number of personal expenses of the owner or his family. Historically, the Commonwealth has seriously neglected the field audit function; today I do not believe there exists within the industry even the belief in a credible threat of a competent field audit. Without field audits and without the credible threat of one, the Rate Setting Commission's reliance on cost reports is far too absolute and the potential, if not the invitation to abuse and fraud, is quite obvious. The failure to effectively field audit is something like limiting the powers of the Internal Revenue Service and insisting that all tax returns will remain accurate because the Internal Revenue Service will do only desk audits to check the addition and subtraction.

Historically, and up to the present the Rate Setting Commission does not have enough auditors or the resources to conduct the federally required number of annual field audits. The Rate Setting Commission is limited to doing desk audits. In the course of Attorney General Bellotti's investigations into cost report fraud, we have uncovered many types of personal expenses hidden in the cost report; none of these examples could or would have been uncovered, detected or even suspected on the basis of a desk audit:

- Expenses for travel and Vacations
- Expenses for Summer House Rentals
- Expenses for Painting in the Private Residences

- Camera Equipment
- Stone Wall Masonry done at Residence
- Expenses for Rock Removal from Farm Fields
- Expenses for the Removal of Dead Trees and diseased Dutch Elms from the residence
- Expenses for Putting in a New Lawn at Residence
- Personal Food Expenses Charged to Nursing Home
- The Remodeling of a Bathroom at a Personal Residence
- Expenses for Furniture, Appliance and Fixtures in the Personal Residence
- Restaurant Expenses
- Expenses for the Salaries of Nursing Home Employees, Who Worked Not in the Nursing Home but at other locations
- Expenses for the Salaries of Members of the Owners' Families who Had No-Show Jobs at the Nursing Home
- Expenses for Oil Heat at the Owners' Private Residence
- Expenses for the Owner's Telephone Bills at his Private Residence.
- Expenses for the Purchase of a Motorized Camper
- Expenses for Plants, Shrubs, and Landscapping at the Owner's Residence
- Expenses for Wallpaper and Paint Work Done to Private Residence
- The Owner's Children's Private School Tuition

Expenses for Cow Feed

- Expenses on a Lease Covering Nonexistent Furniture Equipment, and Beds
- Over $100,000 in Claimed Expenses that Were Non-Existent "Add Ons"
- Expenses that were Never Paid to a Nonexistent Management Company

I know this list is not exhaustive. It does not include matters that are under investigation or pending prosecutions that could be called for trial. In one case not mentioned so far, the Rate Setting Commission did detect something suspicious about a provider's cost report, while it was conducting a desk audit. In that case the provider not only brought its cost reports to the offices of the Rate Setting Commission but brought as well approximately $250 thousand worth of blatantly home-made phony invoices by which it was trying to substantiate its exorbitant expenses. Unfortunately, the provider chose the address of an abandoned gas station as the address of its nonexistent payroll computer company.

In that case the very fact that the provider had the nerve and audacity to present to auditors of the Rate Setting Commission hundreds of invoices each of which were identical except for the amount claimed and the typed-in vendors' name says something about that provider's belief in the Rate Setting Commission as a credible threat.

In order that these hearings or others like them do not become ritualized and get repeated in two or three years, the Rate Setting Commission in the first instance must become a credible threat to cost report fraud.

To some real extent the Internal Revenue Service acts as a visible deterrent to tax fraud. The Internal Revenue Service has created and continues to maintain the credible threat of a competent audit of a person's or corporation's tax return. If that deterrent were removed, no great amount of speculation is needed to determine what the probable consequences would be. But the function of a cost report is very similar to that of a tax return yet for all practical purposes, the cost report is subjected to merely a cursory desk review in order to determine the mathematical accuracy. And some of the consequences of the failure to do field audits were the examples I gave earlier of personal expenses hidden in cost reports.

The Rate Setting Commission's inability to secure the resources necessary to create the visible credible threat reflects a truly penny-wise and dollar foolish policy. And perhaps even something worse flows as a consequence of that policy. If the entire industry knows that its cost reports will not be realistically and competently audited, an atmosphere inviting fraud and abuse tends to be created. The Rate Setting Commission, knowing that it cannot perform field audits, will come to use the desk audit as an aggressive and sometimes seemingly arbitrary defense against legitimate and illegitimate increasing costs. Hundreds of honest nursing home owners will have legitimate costs seemingly arbitrarily disallowed by an auditor attempting to do via a desk audit what simply cannot be done. The institutional industry's perception of the Rate Setting Commission's function will come to be that it is arbitrary, capricious, unfair, and even conspiring to destroy the industry. With the filing of each new cost report, the institutional owner anxiously awaits an auditor's desk review decision on disallowances that have a trememdous impact on the existing cash flow problems of the home for the next year and perhaps several years thereafter. And with all of this against the background knowledge that the Rate Setting Commission is unable to perform field audits to accurately and fairly verify costs, it is little wonder that some significant padding of cost reports goes on. And when discovered and prosecuted, it will not be uncommon to hear the owner claim through counsel to the Courts that the Devil made him do it. Although I do not know the industry's formal position, I would think it would be in its long term interest to support the

Commission's request for substantially more auditors in order to perform field audits. By doing so it would be ensuring that fair and equitable rates would be set based on costs audited and found to be connected to the operation of the home. If it refuses to support the Commission's needs, then it will be ensuring that the perceived, unfair and almost blind desk review disallowances will continue; and so will the present atmosphere inviting fraud and abuse. And if any conspiracy exists to destroy the industry, the industry itself would have to be found to be a co-conspirator.

Without change in the present priorities, without assigning some real PRIORITY and MONEY to the efforts of both the Rate Setting Commission and the Department of Public Welfare in verifying provider costs and services, by maintaining the status-quo, we will be ensuring that these broad brush hearings are again repeated in two or three years just as they were conducted two or three years ago.

Chairman DOLE. Our next witness will be Mr. Richard Kusserow, Inspector General of the Department of Health and Human Services; and I might say you can summarize your statement, as I know you will. It will be helpful. You have heard probably nothing new this morning. I don't believe we have heard anything new this morning. We've had it dramatized in a little different way so we look forward to your testimony and knowing what plans are in operation to reduce fraud and abuse in this administration.

Chairman HEINZ. Mr. Chairman, before Mr. Kusserow begins, I just want to add one small footnote. We didn't plan it this way, but today is Mr. Kusserow's birthday. And as we indicated earlier, the investigation by the Aging Committee staff took place long before he became appointed Inspector General this year, this administration. Our investigation ended in December 1980.

I hope you can accept this birthday present that we have presented you, and that you know how to use it well.

RICHARD KUSSEROW, INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. KUSSEROW. Thank you, Mr. Chairman. Mr. Chairman and members of the committee, I am appreciative of having the opportunity to appear before you. And I will confine my remarks and make them brief to allow maximum time for questioning. Obviously, from what I have heard there are a lot of questions that will require some answers at this point.

I do feel some ambivalence on one point. I never thought that I would have to establish my pedigree as a canine. [Laughter]

Now I would like to give some very broad brush impressions that I have acquired as a result of the last few months as one of the new Inspector Generals.

As you know, the Secretary for Health and Human Services, Secretary Schweiker, for many, many years sat where you are sitting now and observed many of the things that you are observing. And he participated in the development of many of the programs that we now have and is looking into both as an auditor and also from the standpoint of an investigator.

His concern, is that the intent of Congress which is stated in the legislative history of our programs is being lost, at times, in the Department's implementation process.

He noted, as you have noted, that little progress has been made by the Inspectors General in attacking the process that generates the fraud, waste, abuse, and lack of economy in the programs.

So I am here as an Inspector General for the Department of Health and Human Services, as a committed agent for positive change for the Department, at the behest of Secretary Schweiker, and the President of the United States. As such, it is my responsibility, to look at the processes which foster the fraud, waste, and abuse and to recommend solutions that correct the processes.

I would like to make my point by way of analogy, if I may. Being that we are the Department of Health and Human Services, I would like to use a health analogy. If the diseases that we are supposed to be addressing are fraud, waste, and abuse, and lack of economy, then I submit that many of the things that we have heard today—the criminal attacks on our programs, the audit findings, the programs that are not functioning properly as observed by management analysts—are all, in fact, just symptoms and not the diseases themselves. If so, then it is a primary responsibility of the Office of the Inspector General to focus on those situations where you have audit findings, identified attacks on our programs through criminality and to use that to track back and identify the disease so that you can treat the disease and not just the symptoms.

The thrust of this Inspector General will be to focus in on the processes which foster the problems rather than what comes out on the other end. As a by-product of concentrating on the processes, there will be a lot more detection of criminal activities; more prosecutions; and more significant audit findings. But they will be as a by-product rather than as the main thrust.

Also I believe that the Office of the Inspector General is responsible for providing a catalyst and a leadership in the development of a concerted effort to focus on specific problem areas.

What we have seen here this morning, already, is the fact that there are no shortages of agencies that are trying to address fraud, waste, and abuse. However, each are going out independently of one another and trying to focus on their one little part of the universe, when, in fact, what we should be doing, inasmuch as we are so fragmented and we have such small resources against such huge problems, is that we should really be trying to coordinate among ourselves and to try to solve some of these problems.

So with that as a preface, let me be prepared to answer your questions.

[The prepared statement follows:]

STATEMENT OF RICHARD P. KUSSEROW, INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Good morning Mr. Chairmen and members of the committees. I am Richard P. Kusserow, Inspector General of the Department of Health and Human Services. I welcome this opportunity to appear before both the Senate Committee on Finance and the Special Committee on Aging to discuss my offices' efforts in combating fraud, abuse and waste in Federal programs.

As you know, HHS's budget is approximately $250 billion (35 percent of the entire Federal Government), the majority of which predominately go to the so-called entitlement programs.

The Department has a total of some 284 programs and about 35,000 grantees, all subject to audit. We also are charged by the White House with auditing all Federal money at 96 percent of the colleges and universities receiving Federal funds. The problems confronting the Department are monumental.

The opportunities for fraud, waste and abuse are staggering, and those of us who have been toiling the fields, combatting these problems have been staggering a little too.

Certain underlying premises behind the development of the entitlement programs are proving to be invalid. For instance:

(1) The emphasis in the development of the programs was on delivery of services at all cost (get the benefits out) and on eliminating red tape—which translated, meant controls. Thus the adage: "everyone in sales and no one in management."

(2) The second premise was that people in the helping professions (service providers) were all committed to the delivery of good services and motivated to help recipients—the implication being that the professions could be relied upon to police themselves.

Well, if all doctors and other professionals subscribed without reservations to their ethical standards and oaths and were somehow immune from the temptations to fudge, cheat, abuse and defraud, things might have been alright. However, certain professionals have not subscribed to this premise. These include some of the Nations' pathologists, radiologists, general practitioners, surgeons, clinical and laboratory technicians, nurses, social workers, nursing home operators, day care operators, pharmacists, dentists, as well as some public officials.

Hence, for those who desire—an open invitation to violate the programs for their own benefit has existed.

We now know that the system has to be repaired by the addition of controls and better detection and screening techniques to reduce: fraud, waste, abuse and the general lack of economy in the programs.

Today I'd like to give you a broad brush picture of the guiding philosophy of this Inspector General in relation to the fraud, waste and abuse syndrome that exists.

Forgive me if I illustrate by analogy—a health analogy, inasmuch as I'm from health and human services.

We all know that it is bad medical practice to treat symptoms. If fraud, abuse and waste are the disease, then adverse audit findings and detection of criminal activities are the symptoms.

Continuing with the medical analogy, we know that one of the most effective means of controlling the spread of communicable disease is modifying the environment in which it thrives: we must create an environment in which fraud and abuse cannot find nourishment; an environment of compliance and respect for rules of conduct and law.

To do this, all aspects of our programs, from their administrative rules down through their claims payment process, must be constructed so as to be clear, unambiguous and enforceable and thus conducive to non-fraudulent and non-abusive conduct.

We must also assure that the prosecutive climate creates an environment conducive to compliance. The need for aggressive prosecutive effort against program fraud is underscored now because:

1. The budgetary belt has tightened at Federal as well as at State and local levels—and temptation to divert scarce program monies from their intended use may increase.
2. As administrators we are accountable to the public to assure the appropriate expenditure of evey tax dollar.
3. A pervasive anti-fraud and abuse effort can provide greater positive visibility to our program, which will enlist greater public and legislative support.
4. Fraudulent conduct is frequently associated with poor quality of services and patient care.
5. Aggressive prosecution should serve as a deterrent to other potential lawbreakers.

The steps I'm taking to reduce the environment conductive to fraud include the following:

1. Linkage and leverage of audit and investigative findings to effect change in program management and reduce opportunities for fraud, abuse and waste.
2. A unit to review and comment on all regulations being formulated in the Department to assure auditable standards and to prevent opportunities for fraud and abuse.

A similar review of all existing regulations so that those which are not conducive to good practices and management are modified or eliminated.

3. Development of a more effective deterrence to individuals tempted to defraud our programs including better coordination with other law enforcement agencies, FBI, Postal Inspection Service, Secret Service, IRS, etc., as well as other IG's and improvement of the quality of cases being referred to the DOJ for prosecution.
4. Greater emphasis on using administrative sanctions as a deterrant (debarment, employee sanctions, etc.)
5. Development of a civil fraud response. The OIG has never developed a capability to respond investigatively to civil fraud.
6. A concerted effort to identify the factors within the system that permits fraud and abuse to occur. That requires a special type of analytical function described in many ways, e.g., vulnerability assessment, risk analysis, etc. We established the first analytical unit among the IG's which I might add has proved to be a model for several other organizations.

Through analyzing a program for fraud prevention and detection purposes, we have found that it is also important to know whether certain aspects of a program's design or implementation increase the probability of fraud or decrease an agency's ability to respond to fraud once it has occurred. It is also important to determine whether persons involved with the program are given any incentive or support in trying to reduce fraud and abuse.

While fraud in Government benefit programs takes many forms, through analysis, we have found that two basic patterns exist that are common to virtually every program. First, there is misrepresentation of eligibility—whether (a) by beneficiaries who seek aid to which they are not entitled, (b) by service providers who ask reimbursement for services never provided, (c) or by agency personnel who set up "ghost" recipients. Secondly, there is misrepresentation on claims by beneficiaries, service providers and agency personnel.

Considering these factors, in 1981 we are very fortunate to be able to use modern technology as an analytic support in our fight against fraud and abuse. By modern technology I specifically mean computer technology and all it can do for us in this area. Prior to the advent of computer technology when we had to do everything manually, the analysis of data about known fraud and abuse cases in order to detect patterns of abuse consumed enormous amounts of labor-intensive effort. While we have certainly not eliminated manual review from the analysis of data, much analysis can be performed rapidly and reliably with the simplest of computer techniques, and this constitutes a major step in the overall effort to control fraud and abuse.

We have found—or rather used, to date—three general types of computer applications to detect fraud and abuse: (1) computer matches, (2) computer screens, and (3) selective case management.

Among these, the computer matching techniques have been the most prevalent to date. The underlying logic of computer matches—as most of you know—is very simple. It is to compare data from two or more data sources in order to detect potential program inconsistencies. Computer screens, unlike the rather simple logic of the computer matches, are designed to identify potential fraud and abuse cases that possess one or more particular characteristics—characteristics that through risk analysis lead us to believe that they constitute statistically sound patterns of deviance, such as more than one hysterectomy on the same patient, pregnancy tests for males, daily prescriptions for same patient, etc. In the third instance, selective case management techniques are applied—based on developing a characteristic case profile commonly associated with fraud and abuse. Once the prototype profile has been developed, this is applied against the data base to detect potential fraud cases.

I will discuss examples of each of the above techniques shortly. First I would like to say that these computer techniques are not a panacea to fraud and abuse control. Their effectiveness is influenced and limited by (1) the integrity and sufficiency of the data base used, (2) the adequacy of administrative and management support, and (3) the legal aspects of computer matching. With regards to the latter, the constraints—felt especially at the Federal level as mandated by the Privacy Act of 1974 and later elaborated in the form of OMB guidelines for computer matching—still tend to restrict fraud detection by measures aimed at protecting the privacy rights of individuals. We are hopeful that the more burdensome aspect can be modified. (I am co-chairman of the matching committee for the President's Council on Integrity and Efficiency).

Now I would like to talk about some of the projects that we have underway now—most are in the experimental stage in that they are limited to a particular programmatic focus or geographic area. Once the bugs have been ironed out and the potential cost-effectiveness of these efforts more fully understood, they can be expanded and amplified.

Our project examples will be grouped where possible according to the previously mentioned categories of: computer matching, computer screens and selective case management. Some projects will have elements of more than one approach. In addition, you will see examples of the basic fraud patterns mentioned before—misrepresentation of eligibility and misrepresentations on claims.

Under computer matching, we have, of course, the AFDC interjurisdictional match effort which I know most of you are familiar.

A. It involves a comparison of AFDC data tapes from participating States in order to detect individuals who appear on more than one State AFDC beneficiary role. This project has been an ongoing one for several years.

B. We are working on an increasingly broad scale with other Federal departments, most particularly, Department of Agriculture. We have several joint projects with them wherein we make a computer comparison of the State's food stamp files and their wage reporting records. The result is the detection of food stamp recipients who are working and not reported earnings to the food stamp program. The fist cut "hits" are then matched against AFDC, SSI, medicaid and public housing assistance programs. In Tennessee alone, there have already been 54 indictments (14 Federal, 40 State) and initial identification of $3.2 million in unallowable costs.

In Texas, we used our Numident program to identify invalid social security numbers (SSN's) in 1.6 million records (450,000 AFDC and 1.2 million food stamps).

This computer match resulted in the identification of 5,098 recipients (1,700) AFDC and 3,400 food stamp with unissued and thus invalid SSN's in the State agencies' records. Phase two—determining the reasons for and effect of recipients having invalid SSN's—is in process (approximately 75 percent completed).

A large number of these invalid SSN's (approximately 3,000) are the result of simple administrative errors—transpositions or keypunching errors. Correction of these errors enables the States agency to obtain employment information on the new SSN's from another State agency and make eligibility redeterminations.

In other cases, the recipients: could not be located (959); claimed to have lost social security cards or provided an invalid number (165); and refused to provide a social security card (95).

Since the project started, 2,224 of the 5,098 recipients have been denied further benefits with an estimated annual value of $1.6 million. We are currently analyzing the reasons for these benefit denials to determine those directly attributable to this project.

Two more recent undertakings involve our death termination computer matches. In one project, we compared HCFA's medicare death records with the social security's retirement, survivor's and disability insurance master beneficiary tape. We uncovered approximately 8,500 cases of unreported deaths in which social security was still making payments. Each case, we estimated, was costing the Government approximately $13,000. In all, SSA has paid out more than $60 million in overpayments to deceased persons. More importantly, as SSA cleanses its tapes, approximately $26 million will be saved annually in future payments.

Our black lung project involved a similar computer match of beneficiaries to death records. Our investigators discovered overpayments being made in approximately 1,200 incidents, totally about $15 million. All of these have been turned to the Social Security Administration, with approximately 500 cases being sent to the Secret Service for further investigation.

We anticipate that additional investigative cases will emerge from these projects as case files are reviewed. Computer screens on the other hand, look for potential cases of fraud. Some recent OIG examples include:

Numident program which scans SSN's and identifies those which have not been issued. The project has identified 151 recipients actually using social security cards with numbers the Numident shows as not issued by SSA. The authenticity of the cards is very doubtful and field investigation of some of these recipients is already underway by OIB/OI. The annual value of benefits received by these recipients is estimated at $106,000. It should be noted that the pilot project was done in a State in which AFDC benefits average $108 per month while such benefits average in other States $277 per month.

We have a project in Connecticut by out investigative staff to identify individuals who have created fictitious children in order to receive AFDC benefits. The approach involves the comparison of the AFDC records against medicaid tapes, school attendance records, and vital statistics records.

In cooperation with INS, we have established a joint national effort to detect cases where SSN cards were illegally obtained by aliens. SSA records were matched against INS records to identify potential cases where work related SSN cards were obtained.

Scans of the potential hits were also made to detect large numbers of cards going to the same individual or groups of individuals. SSA employees were convicted of possessing illegal accounts, and more than 100 conspiracy cases are in development. To date, 50 convictions have been obtained and INS has deported 800 aliens as a result of the project. This effort reflects both the elements of a simple computer matching technique as well as that of a computer scan.

We are developing screens to catch totally inappropriate prescriptions by medical providers: That is, making the initial diagnosis, analyzing proper medical options at each step, and identifying deviance from good medical practice. (That is, if the complaint and diagnosis relates to an ear infection then an arm X-ray or eye glasses would seem to be inappropriate.) It is considerably more complicated than that but I think it gives you the idea.

Our final approach, selective case management, is quite close to the approach used with the computer scans. Its purpose is to identify potential fraud and abuse by using computer screening methods to identify profiles of individual cases possessing common factors. These factors could include families listed with (1) no income (earned or not), (2) no medicaid received for children, (3) all the kids under 6 years of age.

In an era of declining resources, it is all the more important that I work closely with other divisions of this department; with agencies and departments; with the

President's Council on Integrity and Efficiency and Members of Congress. This is already happening in many of our operations and with Secretary Schweiker's encouragement, I expect to continue.

Thank you.

Chairman HEINZ. Thank you very much, Mr. Kusserow.

You have been given a very heavy responsibility by OMB to conduct audits of major immensity. To what extent have the budget cutbacks—will they adversely affect your ability to do your job?

Mr. KUSSEROW. It's very difficult to say at this point. I think that the one thing I can say uncategorically is that if we had more resources, it could be well used. But at the same time, the concern I now have is that I do not believe that the resources allocated in the past to this office have been used to full measure.

So, I think my first responsibility to the Congress is to demonstrate that I can use, to the best advantage, the resources that you have given, before I start thumping too hard for additional resources.

My greatest concern at this point is harnessing the resources that we do have, not only within the Department but within the community of the Inspector General, and to try to rally those resources in a way that we are all pulling together rather than at cross purposes.

Chairman HEINZ. Now one of the things you have been asked to do, I gather, is work very, very hard on the student loan program or the college grantees. Is that right?

Mr. KUSSEROW. We did that a great deal when the office of Education was part of our program, but since it has been pulled out, we have only focused on those loan programs related to the health field. We are now undertaking several major initiatives regarding the health professions loan programs.

Chairman HEINZ. Well, what specific steps are you taking to assure that your office targets its resources most effectively to the programs that are most vulnerable to fraud? We have heard some pretty interesting stories today about medicare, medi-cal—that is our medicaid program in California—social security disability. Where do you want to start? What are your highest priorities?

Mr. KUSSEROW. Well, first and foremost is that we should have an effective office of the Inspector General. I hold the office, signed, sworn, and delivered as such, but I must confess that my impression of what was expected of me from within house was considerably different than what I expected the job to be.

I think many looked upon the Inspector General as some sort of honorary Kentucky colonel that is supposed to oversee jointly two independent arms—a criminal investigative arm and an audit arm—and that they work through an inbox, outbox routine.

What we need is an executive at the Inspector General level to merge, as was intended by Congress, a single force to address the problems across the board.

What we have now is an audit agency and a criminal investigative agency—two separate arms. This is my priority—to merge these two arms into a single integrated force.

Chairman HEINZ. What's to prevent that from being done?

Mr. KUSSEROW. Nothing. In fact, I would hope that by next year if you do not have an Inspector General sitting here that you will have returned him to the cornfields of Illinois. It should be done. And it can be done. And it will be done.

One of the first steps that we need to do, is to recognize that there are shortcomings in the way we have been approaching the problem in the past. We talk about the criminal prosecution and we talk about the audit, but there are considerable ranges of sanctions in between that have never been addressed by this Inspector General. And I would suspect not by many other Inspectors General.

For example we see an individual that may have ripped off a system for $1 million and he gets a light sentence of probation and maybe restitution of a small amount, maybe even a $5,000 fine—you really have not hurt them.

But suppose we were to exercise, which we have already in statute, some of the civil fraud provisions go after that individual for treble and punitive damages, for damages on every count that they participated in; we could put them out of business. If they take $500,000 from this Government, we should get that back plus more . . . from punitive damages.

This way, you could do more harm than prosecuting them and permitting them to go back with their license and continue practicing. And as we have seen this morning, they could continue practicing and committing additional frauds in other programs.

So I think that one of the sanctions that has not been utilized to any degree has been the civil fraud sanctions.

Another area that we need to look at is, for example, when a person has been found engaging in fraud in one Government program; is caught, but does the same fraud in another Government program. They should not be allowed to go to a different trough of another Federal program and drink from that. We should at least be aware of situations where a doctor who has committed a crime against Medicaid might also be committing a crime in the Medicare program; or might be receiving a research grant at NIH, or is working for the VA as a physician at one of their hospitals.

There have been cases like this, and this morning I think we have some confirmation of that. There is a tendency—that when a person has demonstrated propensity to commit a fraud against the Government that they will have a tendency to continue doing that in the future. We really must make an effort to be aware of people that have done that.

We are developing a national strategy under the aegis of the President's Council on Integrity and Efficiency, chaired by this Inspector General, to look at the entire spectrum of medical provider programs in the Federal Government. As it stands now, about 95 percent of that Federal dollar that is going out is coming out of our Department. But every single other Department in our Government has some sort of medical provider program. We need to understand those programs. We need to understand what is going on with them.

Chairman HEINZ. Mr. Kusserow, let me interrupt so that we can proceed with the order of questioning here. I have got a number of concerns I'm not going to ask you about now. I am going to submit a set of questions to you in writing. We have got a number of things to cover. I would like to know, for example, about the computer matches and the number of leads. Whether you have got sufficient resources to follow up those leads and a whole bunch of specific questions like that. But rather than take the time of the committee to get into each and everyone of those, I think I will simply yield to Senator Mitchell, who, I know, has some questions too.

[The questions follow.]

Question 1. In 1977 the Senate Special Committee on Aging estimated 10 percent of Medicare and Medicaid was being lost to fraud, abuse and waste. One of your predecessors, Mr. Morris estimated in 1978 the loss in programs under the jurisdiction of the Department to be $6.3 to $7.4 billion. What is your estimate of the current loss to the programs from fraud, waste and abuse? Is there any reason to believe that proportion lost to these activities has decreased since the establishment of the Office of Inspector General?

Answer. As indicated at the time those figures were released, the purpose of the estimate was to focus attention on the existence of significant problems. Although staff eventually revised those estimates downward—$5.5 to $6.5 billion—the estimates were never intended nor presented as a single point estimate since it was a collection of estimates of varying validity.

These estimates resulted, however, in a significant Departmental response. Although much progress has been made, much remains to be done. Because of the difficulty in gathering comprehensive and accurate data, OIG has not attempted to update the earlier estimates, Instead we have attempted to focus our attention on those problems we consider to be most serious and capable of immediate improvement.

I believe that OIG work has resulted in a decrease in the relative amount lost to fraud, abuse and waste. Certainly, I find that Secretary Schweiker and agency heads give this high priority. Nevertheless, much remains to be done and I intend for OIG to make an important contribution in reducing these losses.

Question 2. Senator Mitchell requested you to furnish the Committees with your best estimate of the staffing needs of your office. Does your office require additional personnel to accomplish the mission Congress intended? If so, please detail number, training and probable assignment of these people.

Answer. As I testified on December 9, before I can request additional resources of Congress or the Secretary, I must determine whether the staff and resources now at my disposal, are being used effectively and efficiently.

I am in the process of making that determination. I am developing a reorganizational plan and a new workplan—priority of work—for the Office of Inspector General. Within a new organization and with a new priority of work, it is my intention to use every person on the OIG staff to their maximum capability. If, after a reasonable period of trial and testing we find that there are gaps in our operation resulting from a lack of resources, we will then make the necessary requests for assistance.

Question 3. Given the size of the problem and available resources, what priorities have you established for your office? How will resources be targeted?

Answer. At this time, my main priority is, first, to complete my analysis and evaluation of my office and the nature of the work to be done and second, to implement a needed reorganization and establish a multi-year workplan—the priorities for OIG work—as expeditiously as possible. Both of these are still in draft but will be essentially completed within three weeks. Upon completion, I welcome the opportunity to brief you on this matter.

Question 4. What present involvement, if any, does your office have in efforts to control organized crime activities associated with programs under the Department's jurisdiction? What role, if any, is anticipated for the future?

Answer. Although alert to the possibility of organized crime activity in HHS programs, this office has not had a major role in these type investigations, as over the years no significant organized criminal activity has been apparent. Individual organized criminal figures have surfaced in isolated investigations conducted by this office, and these matters have been handled on a case by case basis. Any investigation indicating widespread influence by organized crime would be referred at once to the FBI, which has greater resources and more expertise in this area. Naturally, this office will remain watchful for this type of activity, and we are prepared to assist the FBI in any investigation into organized criminal activity related to the Department's programs. In that regard, the Inspector General recently sent a letter to the Director of the FBI offering the assistance of this office in any investigation involving organized criminal influence in the Department. The letter also contained a request for the FBI to furnish this office with any information they have that indicates organized criminal activity is being directed against any of the Department's programs.

Question 5. What present involvement, if any, does your office have in efforts to police intra-state and chain activities associated with programs under the Department's jurisdiction? What role, if any, is anticipated for the future?

Answer. We have been active in seeking chain activity violations and foresee an even more active role in the future. Past activities include:

First, this office funds and oversees the operation of 29 State Medicaid Fraud Control Units, whose responsibility is to investigate and prosecute providers who defraud the Medicaid program. Additionally, we maintain liaison with those States not having specific fraud control units and provide them with technical assistance whenever possible.

Second, we have been involved in several investigations and audit probes of chains of Medicaid and Medicare providers. These have largely been detected, investigated and prosecuted by a combination of Federal and State agencies with this office and the Department of Justice coordinating Federal participation. A good example of this is our recent investigation of the Montgomery Investment Corporation of St. Louis, which managed, owned and leased 13 nursing homes and 20 other corporations. In conjunction with other agencies, our investigation was able to demonstrate how the owners pyramided costs between their organizations and then passed these higher costs onto the Medicaid program through increased reimbursement rates.

Third, we co-sponsored a three day planning conference in 1981 to achieve better mutual understanding and arrangements for handling chain-type cases. Represented at this conference were the FBI, the Department of Justice Criminal Division, several State Medicaid Fraud Control Units, and various Assistant United States Attorneys, most of whom were economic crime specialists. We will continue to maintain and encourage liaison among investigative and prosecutive agencies.

Fourth, under our upcoming reorganization, we will be taking a more active role in obtaining civil and administrative sanctions against all providers who abuse and defraud our programs. We will also encourage and assist other agencies in obtaining these civil and administrative actions.

Question 6. The Committee expressed concern for the lengthy period between the initiation and completion of a health case. How do you plan to speed up that process?

Answer. The time required to do an investigation of a health provider case is impossible to predict for a variety of reasons. In most situations, the cases brought before us are extremely complex and time consuming. Because of the complexity and nature of the cases, generally a full scale audit of the books and records is necessitated. Since they are primarily volume transactions, it requires large amounts of time and manpower. Further, it is difficult and complex to convert the audit trails into the evidence needed by the U.S. Attorney. Finally, documents do not speak for themselves and witnesses must be developed to testify concerning the evidence. For example, the Kones case required over 1200 hours of OIG investigation staff time. That does not include the staff time other law enforcement agencies may expend to close the case. Consequently, even though we would like to speed up the process, it is not always possible.

We are examining new ways of sharing cases with law enforcement agencies during the early stages of an investigation. New communication technologies clearly have the potential of assisting us in this area. Also, we are working, within the Department, to insure that information and allegations move expeditiously to investigative agents.

Question 7. You indicated in your testimony an intent to reorganize the Office of Inspector General. How do you envision the Office functioning? Will your reorganization affect all three of the Office's principal components or just the audit division? When is it anticipated the reorganization will be completed? Please include with your description your rationale for the changes to be made.

Answer. As I testified, the reorganization of the Office of Inspector General is being developed now and will be completed shortly. At that time, I will welcome the opportunity to brief you of the changes I will make and to answer any questions you may have.

Chairman HEINZ. When that bell goes off there, it means my time as well as yours has expired.

Senator MITCHELL. Thank you, Mr. Chairman.

Mr. Kusserow, do you agree that the detection, prosecution, and punishment of provider fraud is one of your highest priorities?

Mr. KUSSEROW. I would say that it would have to be the highest priority.

Senator MITCHELL. The highest priority. All right. And you intend to do what you can as effectively as you can about that, I am confident.

Mr. KUSSEROW. Yes, sir.

Senator MITCHELL. Right. Now I asked this question this morning. It's a very simple one. Whether or not when a provider registers for reimbursement under any program within your jurisdiction, do you know whether that person is asked by anyone, either on a form or orally or by some other means, whether or not that person has a prior criminal record of any kind?

Mr. KUSSEROW. He is not asked that.

Senator MITCHELL. All right. Don't you think that would be a good, simple thing to do?

Mr. KUSSEROW. I would think not only that, Senator, but I think another area you might want to explore is the fact that maybe you can work some sort of a condition precedent to participating in a Federal program.

Senator MITCHELL. Well, that's a second step.

Mr. KUSSEROW. I agree with you.

Senator MITCHELL. I would like to have you determine—it doesn't seem to me you need legislation to do that, but if you do, I would appreciate you telling me that. And if you don't, I would appreciate your instituting that practice. It seems to me that Dr. Kones' case is a classic example. If someone had known that this man had a prior criminal record of precisely the type of fraud which he subsequently engaged in, it would have been much easier to detect, indeed prevent, the occurrence that did, in fact, later happen.

So I would urge that upon you. And I would like to have you tell me in writing whether or not you have either instituted that practice, why you haven't done it and if you need legislation. Would you do that?

Mr. KUSSEROW. Yes, sir.

Mr. KUSSEROW. We are in the process now of reviewing it. We require some assistance in that matter. We have already determined that there are some legal impediments to doing that so I will be coming back to you with some recommendations.

Senator MITCHELL. All right. Now you touched briefly upon the question of your budget. And you, I thought, answered by emphasizing the failure of the office previously to fully utilize the resources that exist. And I understand that. And I expect that you will make more effective uses of those resources. But at the same time it seems to me that you face a really staggering task when you deal with the entire budget which you have described in your statement at $250 billion, 35 percent of the entire Federal Government. And I wonder if you would provide us, also in writing since the time is up here, of your most realistic analysis of the level of resources you need to do the job as effectively as you feel it can be done. And I want to make that clear. I know you are a good fellow and you are going to say you are going to do the job effectively at whatever level of resources are provided to you. But I am asking you to provide us with a statement of what, from your standpoint, is the level that would provide the most effective enforcement of your responsibilities.

Do you understand the question?

Mr. KUSSEROW. Yes, sir.

Senator MITCHELL. All right, thank you. And I look forward to receiving that from you, Mr. Kusserow.

Chairman DOLE. Senator Pryor.

Senator PRYOR. How long have you occupied this position?

Mr. KUSSEROW. Since June of this year, Senator.

Senator PRYOR. I was intrigued by your opening statement. Basically, the inference that I gathered was that we don't have an Inspector General in the HHS.

Mr. KUSSEROW. I hope to correct that, in fact, rather than just in theory. Yes, sir.

Senator PRYOR. So you really do think we do have an Inspector General?

Mr. KUSSEROW. The Office of the Inspector General is there. One of the things that I believe—and I haven't really had a chance to go through the report that was given to me as a birthday present—should be made clear. During the entire calendar of 1980, you had no confirmed Inspector General at the Department. For 2 years now you did not have a confirmed Inspector General sitting in the Department of Health and Human Services to provide leadership and to do some of the initiatives that I think are imperative.

In that context, coming in after a hiatus of nearly 2 years from the first Inspector General and to the second Inspector General, which I am now, a lot of institutional problems have developed that need to be corrected. Once they are corrected you will have in fact as well as in theory an Inspector General.

Senator PRYOR. My perception of you is—and pardon if it is wrong—that you are a person who wants to do something. You want to take action. You want to prosecute. You want to put these people in jail or at least impose civil penalties on them. Who is holding you back?

Mr. KUSSEROW. Time. I need time to do that. And the time isn't there. But we, in fact, will be doing that.

But I should say that a primary thrust is that we do know from every study available that in these white collar crimes, these crimes of opportunity, that if you want to really have an effect on it, then you must interdict the process which creates the opportunity. If you remove the opportunity, then you are really going to have an effect on reducing the amount of criminal acts in our programs. So I think one of the things we need to do is to develop strategy to find out not only where people are attacking our programs but how they are doing it and then correct those processes.

Senator PRYOR. Before we discuss strategies—I will borrow a question from Senator Chiles—Why hasn't the office been merged?

Mr. KUSSEROW. It's from the fact that you brought together two such dissimilar professional entities. After all, we are talking about something that is fairly recent in vintage. It's still a mere child by program standards of maybe only 3 years.

By taking criminal investigators and auditors and putting them together, I don't think it really has matured to the point where they should have had the middle ground in between. We should have had more in the way of management review, administrative sanctions and civil fraud——

Senator PRYOR. My only comment, Mr. Chairman, is that in those 3 years that this office of this Department has been, it has had passed through it almost three-quarters of a trillion dollars. And I think all of this strategy business is nonsense. I think you ought to go on and do what you think you should do and I think the Congress would back you.

And I would just like to make one other comment. I know my time is up. But according to my report, the HHS' Inspector General's office ranks 13 today, 13, in cases open per departmental dollar expended. And I think that's a very, very poor track record. And I hope you will improve upon it.

Mr. KUSSEROW. I can because that's something that could be administratively regulated. I'm not sure how valid that figure would be. If we wanted to, I could open 8,000 or 10,000 cases tomorrow. But the important thing is the significance of the cases that we are working and how we handle them. I think that should be measured on the output side rather than on the input side.

Senator PRYOR. My time is up.

Chairman DOLE. Senator Cohen.

Senator COHEN. Just one question, Mr. Chairman.

Why are 36 percent of the pending cases listed as being 6 months old or older in the 1981 report? I think 21 percent are over 1 year old.

Mr. KUSSEROW. I'm not sure I can give you a proper answer to that. I think I can give you a partial answer.

A partial answer would be that cases of fraud of the type that you heard about today from Dr. Kones require an enormous amount of worktime to put together all the documents and evidence necessary to sustain a prosecution. It's not unreasonable to take 6 months or 1 year or even 2 years to develop a worthwhile case.

The question applies to those cases which are not that complicated; simpler cases that really don't require that kind of input, whether they would be included among them, in which there would not be justification whatsoever.

Senator CHILES. I'm sorry I missed your initial presentation, but what are some of the reforms that you would recommend? We didn't get into specifics today with Dr. Kones. But let's take workmens compensation claims, by way of example. You have a situation in which a worker is injured on a job, has a back problem or drops something on his foot; goes to a doctor; starts the whole cycle then. It is almost automatic that there will be a workmens compensation claim filed and allowed. And then the doctor will simply continue for 1 year, 2 years or 3 years sending in slips for treatment that was never actually rendered. What are some of the recommendations that you would make for us to change that? Would you require, for example, the patient to sign on the slip that says, yes, these services were performed? I mean, how do you deal with that problem?

Mr. KUSSEROW. I think a major responsibility will have to rest on my shoulders on that score. It's my responsibility to use not only the investigative, the management analysis, and the audit resources I have, but to then be able to develop screening techniques to surface those types of problems.

We have found that where we know the factors that go into developing an abuse, we can use a machine to go back and to screen out and surface that type of problem area in which case you should be able to not have that happen again.

Senator **Chiles**. What has been evidenced here, I think, today is that you invite fraud and abuse by a laxity of enforcement, a laxity of interest and oversight. You invite it. When you have that kind of profit—we are talking about millions of dollars—with little risk of being detected, then you are almost inviting abuse.

Mr. **Kusserow**. There is a more fundamental problem here. We had some underlying assumptions that went into a lot of these programs and one of those assumptions, of course, was that people in the helping profession, such as Dr. Kones, could be relied upon to follow their hippocratic or other similar ethical oaths. Were that a valid premise, we wouldn't have to develop as many controls as we might in some other sectors. We have found, and certainly Dr. Kones would confirm, that that is not a valid assumption.

A second assumption that creates a problem is that many of the programs developed, include the approach that our responsibility is to get the benefit on the street to the needy. To do that, we cut some red tape in the process. Red tape is a euphemistic term for proper controls. We can balance out proper controls against the beneficiaries' needs, but what we are seeing is the inheritance of a system wherein there are not sufficient or proper controls. People can take advantage of it, particularly, in the helping and health profession.

Senator **Chiles**. I interrupted, and I shouldn't have in your testimony, when I asked you why this hadn't been done. In your rambling answer you seemed to say that if it wasn't done, you were going to go back to the farm. I would agree, you ought to go back to the farm if it isn't done. But I want to know if there is somebody keeping you from doing it?

Mr. **Kusserow**. No.

Senator **Chiles**. You have been there since June.

Mr. **Kusserow**. Yes, sir.

Senator **Chiles**. And you've told about all of these complexities of having auditors and having Inspectors General—investigators—and how in the world do you merge them? Other Departments have done that. That was the intent of the Congress. We want to put the auditors with the criminal investigators. Now what's to keep it from being done?

Mr. **Kusserow**. I would question how successful the other Departments have been. No, there is nothing. We are in the process of doing it. One of the things that we have not done in the past that we are doing now is that we are developing an administrative sanctions package.

In the past, there has never been any tracking within our Department, for example, employees who have been found guilty of committing frauds against our programs or engaging in criminal conduct. We never followed through to see what would happen to them or make recommendations as to what should occur. We are now in the process of finalizing a program, a table of sanctions that are going to be recommended and hopefully adopted by the Department. We are certainly going to track those people and that will be part of our report to the Congress each year.

Senator CHILES. What does that have to do with merging the auditors and the investigators? What does that have to do with what you said about keeping yourself from being the paper pusher with the two functions going between? What's to keep you from putting those auditors and investigators together and you being in charge of them?

Mr. KUSSEROW. They are together. We are collocating them. But what I am saying is that there are gaps that exist in their professional backgrounds. The gaps must be filled. Among the gaps is the area of civil fraud which are not being addressed by our criminal investigators and which is not part of our audit process. That must be made part of our investigations, an administrative sanctions package with a full range of sanctions available to use against a wrongdoer. Administration sanctions to civil fraud, debarment, the civil prosecution to criminal prosecution—all of those things must be together. And we are going to introduce those additional elements to draw them together.

Senator CHILES. The Atlanta Office of Program Integrity between 1976 and 1980 referred a total of 193 medicare fraud cases to the office of investigations for criminal prosecution. That's just in region IV—193 cases and 109 of those are from Florida. As of today, the records show that there has been one successful prosecution, one conviction of a Florida case.

I don't know how much total dollars are involved here. I know the dollars are tremendous. But when is the Department going to do something about this? And when are you going to use your civil money recovery authority?

Mr. KUSSEROW. Well, we have in the reconciliation package a civil fraud penalty bill that we are in the process of now implementing that will be a useful tool in that effort.

Senator CHILES. But the Congress just passed the law that gave you the right to use it. Have you used that? Have you used the law you got passed? I'm getting tired of people coming up here and saying if we had something, if we had a change in the law, if we could just change this, we could do it. Are you using what you have got now?

Mr. KUSSEROW. No, sir. And that's my point. The fact is that we should be using it. One of the reasons why I am sitting here before you today is that I came from the Federal Bureau of Investigation. I was part of a search effort by this administration to come up with a professional that knew how to investigate program frauds, who knew how to make those cases acceptable for prosecution with the U.S. attorneys. It was the belief of the Secretary, and I guess of the President, that, in fact, they had found a foremost expert. And I would trust that their judgment is good on that point. An expert to actually address what you find as being absent in our programs. I would agree with you wholeheartedly that more can be done in this area and should be done in this area. And that's why I am here.

Senator CHILES. Well, I notice again in the records—the way the records are kept, the 1980 Inspector General's report to Congress shows that 41 health cases were referred to the Justice Department for criminal prosecution. Of that 41, 5 resulted in convictions; 31 were declined. And yet I have a list of medicare fraud referrals to the Justice Department that's maintained in the region IV, Atlanta office, that shows in that office alone 46 fraud cases were referred to the U.S. attorney and they were declined for prosecution. That's, again, just in 1980. Now are the figures only 41 cases, or if you listed every region, would you find that every region is like Atlanta and the figures are way the hell higher than that?

Mr. KUSSEROW. I have not had a chance to look at that in detail. But I think what you are seeing there are those cases which were opened, processed, and closed in the same calendar year. This does not mitigate the situation at all. But the actual total number of convictions are in the forties in that area.

But my point is that at the outset of an allegation or at the outset of the information that's received that there is some possible misuse or malfeasance against our programs, a decision should be made as to what is the appropriate vehicle or sanction that should be applied in the final analysis, whether that be administrative sanction or civil fraud prosecution or criminal prosecution or any combination of those. That has not been done in the past. That is what we are going to do in the future. And that's what we are doing now. But in 1980 that was not being done. In 1980, you didn't even have an Inspector General. You had an acting head of the audit agency, acting deputy head of the audit agency, acting assistant for health care review.

Now with an Inspector General and with this approach and by employing these techniques, we can make a very strong increase in that record.

Senator CHILES. My time is up.

Chairman DOLE. Well, first, I think I ought to put in the record—in case some may have forgotten—that Mr. Kusserow has considerable experience in this area, having been with the FBI and having been active in the Pittsburgh area and the Chicago area specializing in white collar crimes, embezzlement, bribery, organized crime, and public corruption. He coordinated many task force investigations, including the Department of Housing and Urban Development real estate broker fraud in 1978; Health, Education and Welfare fraud in 1976; Veterans' Administration school fraud in 1978 and other things. I would say that since he was appointed on June 10 he probably hasn't had time to clean it all up yet. We will probably be back here next year and then I think those might be appropriate questions. Not that they are inappropriate now, they might just be more appropriate after you have had that much time.

Do you need any more authority? Is there any legislation to give you more—are you having trouble with the Justice Department or the FBI? Do you agree with their policy that all potential criminal cases should be referred to the U.S. attorney's office? And then they should decide who takes the lead on these cases?

Mr. KUSSEROW. I think just by the very nature of my background, the conflicts that may have existed between the Office of the Inspector General—certainly this Office of the Inspector General—the FBI and the Department of Justice have been greatly mitigated.

In fact, I am on the President's Integrity Council Law Enforcement Committee that is trying to work out a relationship between Inspectors General and the FBI. The FBI is not interested in assuming the investigative jurisdiction of all of the cases. They don't have the resources to do that.

In the Kones case, what we have underscored here, is that you had joint investigation with the HHS-IG, the U.S. Postal Inspection Service and the Department of Labor IG. We have other agencies in the Federal Government interested in Program Fraud. You have Secret Service; FBI; IRS. I think what we need to do and what is demonstrated here as being a successful way of doing business is to cooperate and work together rather than try to work at cross purposes.

The problems are just too large and the resources are too small to worry about squabbling over who has jurisdiction and who is going to get credit for it.

Chairman DOLE. How many agencies have taken credit for Dr. Kones?

Mr. KUSSEROW. Well, you certainly had the postal inspectors here and I think they would want to take some credit. I think the Department of Labor's Inspector General who contributed a lot of resources to the investigation in pulling together documents—their agency would want to take some credit for it. I think there is some credit warranted to the auditors and investigators of our Department that put it together.

But as far as who is going to claim an actual status concern, they can all claim it if they want to. I am not interested in that. I am interested in trying to correct the weakness that gave him the opportunity to take advantage of our program.

Chairman DOLE. Well, I think you indicate that in your statement. Clean up the environment and maybe it would be a little more difficult to perpetrate some of the fraud and abuse.

As I understand—do you have some agreement with the FBI on the referral of cases?

Mr. KUSSEROW. I think that it is being clarified as we go along. A lot of it is due to the fact that I don't honestly believe the FBI fully realizes what an enormously large agency that we are, and the nature of the problems. In talking a little bit about it they have to come to appreciate it a little better as to what is here. So, consequently, I suspect very strongly that you are going to see there is a very close working relationship where we can provide a lot of program expertise, and they can provide a lot of their expertise that we don't have available to us, and a lot of the resources that we don't have available to us.

For example, we only have agents in 30 of the 94 judicial districts of this country. If you were to think of provider or recipient fraud, by any criteria you would probably think of Detroit as being among the top half dozen, yet we have only one investigator in the whole State that takes the upper peninsula all the way down to the Indiana border. We have nobody in the State of Ohio. And I probably could keep gainfully employed all 91 of my criminal investigators in Ohio alone for the rest of their career. And yet we have nobody left for Cleveland, Cincinnati, Columbus or any of the other areas.

You heard about the meager resources we have on the West Coast. We have State medicaid fraud control units that report to me that are larger in themselves than my whole investigative organization. So we are not competing with anybody. What we need to do is provide leadership and catalyst and program expertise to other investigative agencies to solve some of these problems.

Chairman DOLE. Who, in your opinion, should take the lead on HHS related cases? And who should have primary investigative powers?

Mr. KUSSEROW. I think that would depend upon the circumstance. I certainly would think that in the type of investigation that you saw this morning where you had the needs of sophisticated surveillance equipment, we can't do it. I would say that that is a primary example where we should utilize the FBI. In fact, that was one of the areas of expertise I had in the FBI, running that sort of an operation.

I would think that in the area where you have a need for a lot of program expertise and auditors and things of that sort that we should contribute that resource because we are better equipped to. I think all in all on all major fraud programs or all fraud investigations, I think what we should do is have multiple agencies working on it, each providing their own specialized expertise. So I don't think it's a question of saying who gets it, but I think it is a question of trying to work out together how to solve the problem. So I don't think a hard-and-fast rule can be developed as to how you go about giving one person a case as opposed to somebody else.

Chairman DOLE. I guess I could conclude from your response to that question and others that you are not in need of anything right now. You have the authority; you have the resources. You wouldn't make any request of any committee with appropriate jurisdiction for additional authority whether it be the Finance Committee, Government Operations, some other legislative committee, the Appropriations Committee, or whatever?

Mr. KUSSEROW. I think we do need resources against this problem. My question is is whether this Department is utilizing its current resources to the best advantage. And one of the concerns—we are trying to struggle with this problem within the Department to try to make sure that not only is there no overlap in jurisdiction but that equally important, if not more important, are the gaps that exist between the various entitites of the Department that are trying to address the fraud and abuse.

Chairman DOLE. All right. I hope before you request any additional money that you make certain what money you have is being properly spent. There may be a tendency on the part of some in Congress to load you up with money even if you couldn't spend it wisely.

Senator Mitchell.

Senator MITCHELL. Could I just make a comment on that. He just said he doesn't have a single investigator in the State of Ohio. And what was your earlier statement in response to the question from the chairman? What are the other States?

Chairman HEINZ. Well, he said he could use his entire staff of investigators for the rest of their natural lifetimes in Youngstown.

I assume you got that out of your experience having lived in Pittsburgh and having commuted up there once or twice.

Senator MITCHELL. If that's not a statement that you need more resources, I don't know what it means.

Mr. KUSSEROW. Yes, we do need resources. But I think what we need to do is look first to see how we can utilize the resources that we have better. Yes, I do believe we need more resources against this problem. And we have to come up with it somehow. My question is how I go about asking for those resources and who do I ask those resources of?

Chairman DOLE. Well, first, you would ask us. That would be a good place to start. [Laughter.]

Mr. KUSSEROW. That's right.

Chairman DOLE. But be certain that you can make a case for it. I mean a lot of people ask for resources. Every agency in this town including HHS. That's why we are about bankrupt as a nation.

I think you probably do need more money but my point is that before you make the request, be certain you know where you are going to spend it.

Mr. KUSSEROW. Yes, Mr. Chairman. I would agree with that 100 percent.

Senator MITCHELL. Could I make one comment, Mr. Chairman?

Chairman DOLE. Sure. I want to announce, though, that there is a bald eagle out in the hall.

Senator PRYOR. These Republicans have no sense of humor. [Laughter.]

I would just like to say I came up and fled with my good friends a moment ago. There is a bald eagle, for the benefit of the audience, out in the hall. I wanted to bring the eagle into the room. It is Martha the eagle from Arkansas commemorating or trying to get us some publicity for the resolution that is now before the Senate. And any of you that want to see a beautiful eagle, go out there and see it. [Laughter.] I was going to make the point that HHS is not exactly soaring with eagles these days. [Laughter.]

But I do appreciate that plug.

Chairman DOLE. We will be glad to have the eagle testify. [Laughter.]

Senator MITCHELL. Mr. Chairman, I would like to make one point that arose in connection with some of your questions and Mr. Kusserow's testimony and also through Senator Chiles' question. And that is, whether or not the Department of Justice has a vigorous policy of prosecution. I have served as 3 years as a U.S. attorney. Every one of the 94 U.S. attorneys have far more cases to prosecute than he or she can possibly process. And one of the major functions of the U.S. attorney is to decide what to prosecute and what not to prosecute.

And you can do all the investigating in the world; you can make all the cases in the world, if you can't get them prosecuted nothing is going to happen except the money that you spend in investigation will have been wasted.

I think what is required, Mr. Chairman, is not just this Department but the Department of Justice, the Attorney General, telling each of the 94 U.S. attorneys in this country that this is a matter of high priority that he wants these cases prosecuted vigorously, that he doesn't want—I don't remember the figures read by Lawton—41 referrals and very few number of prosecutions.

Chairman DOLE. I think he has done that.

Senator MITCHELL. That is very encouraging if he has done that, Mr. Chairman, because otherwise they simply are not going to be prosecuted. And all of this work would have been in vain.

Chairman DOLE. Thank you.

Senator PRYOR. Mr. Chairman, may I ask one or two questions?

Chairman DOLE. Sure.

Senator PRYOR. First, what is the number on your staff? How many people do you have responsible to you, Mr. Inspector General?

Mr. KUSSEROW. I have 929 currently.

Senator PRYOR. Nine hundred and twenty-nine. Now just so we can get the record clear, have you asked anyone from President Reagan to David Stockman to anyone else for additional staff people?

Mr. KUSSEROW. I am requesting that at the present time for a continuing level through this calendar year.

Senator PRYOR. So you have asked for no additional staff?

Mr. KUSSEROW. No; but within the Department I am in serious discussion as to how to allocate our resources within the Department. But outside the Department, no.

Senator PRYOR. Within the Department, who are you discussing that with? I mean, are you having trouble getting resources within the Department? Do you have a line item budget item?

Mr. KUSSEROW. Yes, sir.

Senator PRYOR. You do. Well, then, what's your discussion in the Department?

Mr. KUSSEROW. As to how to better allocate the resources that we have within the Department, which includes the Inspector General, in its effort to coordinate efforts against fraud, waste, abuse, and a lack of economy. There are other entities which have resources. And what we are trying to address is how we can best utilize the total departmental resources in this effort, and how we can work together to do that. Now I don't know whether that would ultimately lead to a reallocation of some of those resources within the Department into the office of the Inspector General.

Senator PRYOR. Well, do you think there should be a reallocation of resources into the office of the Inspector General?

Mr. KUSSEROW. Well, we have a survey that is being undertaken currently by the Assistant Secretary for Management and Budget to see whether or not, in fact, we have much in the way of an overlap of effort. And it will be from that that we can try to make some judgment. I am not privy to what they have found thus far. But if not that, then I think we have to work and see how we can better coordinate our efforts within the Department.

Senator PRYOR. How long is it going to take you to find that answer?

Mr. KUSSEROW. I hope we find that this month some time.

Senator PRYOR. Would you be willing to come back to us, say, in about 6 weeks or 2 months and say, yes, we have found the answer or, no, we have not found the answer?

Chairman Dole. Whether he is willing or not, he may be coming back. [Laughter.]

Mr. Kusserow. The one thing that I have found in my tenure to dayt is that it is easy to find what is wrong and it is easy to find the solutions but it's the implementation, that's the difficulty.

As far as a departmentwide strategy is concerned as to how we coordinate our resource against the problem, that should come in a fairly short order.

Senator Pryor. But the problem is you have the power, you have the authority, you have the staff, you have not asked for additional people, you have not asked for additional resources. All you are doing is saying hadn't we better coordinate this whole operation. And, frankly, it is disgusting to see us give $200 million, basically what we are giving to you, and for you not to know any more about what you want to do with it.

Mr. Kusserow. We don't have $200 million. We have—let's say $40 million.

Senator Pryor. You have, I think $194.7 million in 1981.

Mr. Kusserow. No, sir. That's not the Office of Inspector General we are referring to there. I am not sure what figures they are referring to, but that's not our budget level.

Senator Pryor. My apologies to the Inspector General—that's the entire Department—and to committee. That's in billions and it's for the entire Department, not broken out just for the IG's Office, so I want to apologize.

Mr. Kusserow. The point is well taken and that is that you are investing in this Inspector General a lot of resources and that you want to see some return from his resources. That's a fair call. What is it that you want to see? You want to see something to show that we are making some progress against these tremendous problems.

Chairman Dole. Well, I think Senator Pryor was basically on the right page. What this page shows in our report is that most departments, in terms of their Inspector General staffs, have a budget roughly equivalent to $20 or $30 or $40 million per IG position. The Inspector General's Office in HHS is in the $200 million per——

Mr. Kusserow. Yes. For each—I'm sorry, Senator, I misunderstood you.

Chairman Dole. The figures are on page 22 and they show that. And that just means that every person in your operation, as measured by dollars—and that may not be a totally accurate way to measure—has to do between five and six times the work of the Inspector General's staffers in all the other departments.

Mr. Kusserow. That's correct. If you took every individual that works in our Inspector General's Office, including the clericals——

Chairman Dole. Let us know when you get them up to five or six times the amount of work and we will teach the others how.

Mr. Kusserow. Yes, sir.

Chairman Dole. Are there other questions?

[No response.]

Chairman Dole. Well, we thank you very much, Mr. Kusserow. And we will, of course, be in constant touch with your office. And we do want to be helpful if there are areas where we can be helpful. As you understand, we have a responsibility. Ours is somewhat different because we are also elected officials and the American taxpayer is really concerned about the fraud, waste, and abuse. Many candidates talk about fraud, waste, and abuse in their campaigns. And some think you can balance the budget with them. But we are not certain they can do all that. But we do want to make every effort to reduce fraud, waste, and abuse. And we appreciate your efforts. And I am certain there will be additional hearings. We look forward to seeing you again.

Mr. KUSSEROW. Thank you, Mr. Chairman.

Chairman DOLE. And there will be some questions submitted in writing, if that is satisfactory.

Mr. KUSSEROW. Yes, sir.

[The questions follow:]

QUESTIONS SUBMITTED BY SENATOR DOLE TO HHS INSPECTOR GENERAL RICHARD KUSSEROW AND HIS RESPONSES THERETO

Question 1. GAO officials indicated in their testimony that there continues to be problems between the IG and the FBI. What is the status of an agreement with the FBI on the referral of cases?

Answer. Historically, problems have existed in the relationship between this office and the FBI. Many of these problems will no longer exist, as both the Inspector General and the Assistant Inspector General for Investigations came to their positions directly from the FBI and bring with them a greater understanding of the issues which have caused these problems. This office is committed to greater cooperation and coordination between the two agencies, and it will endeavor to resolve those problems that hamper effective enforcement activity.

Question 1b. Who do you believe should take the lead on HHS-related cases and who should have primary investigative power?

Answer. In those cases where the program fraud is of such complexity to necessitate (1) specialized program expertise in order to investigate the matter properly or (2) specialized audit capability to comprehend the intricacies of financial transactions, the Office of Inspector General should take the lead. However, if the alleged crime suggests the need for certain investigative techniques (such as a lengthy undercover operation or organized crime matter) that are more suited to the FBI, or another "main line" investigative agency, then that agency should take the lead and be able to depend upon staff assistance of OIG auditors or investigators.

Question 1c. What is your response to the new Justice Department policy that all potential criminal cases should be referred to the U.S. Attorney and the FBI and they should decide who takes the lead on cases?

Answer. Section 4(d) of the Inspector General Act of 1978 requires each Inspector General to report expeditiously to the Attorney General whenever the Inspector General has reasonable grounds to believe that there has been a violation of Federal criminal law (5 U.S.C., app.). Furthermore, 28 U.S.C. 535 requires that any information, allegation, or complaint received in a department related to possible violations of Federal criminal law by a Federal employee be expeditiously reported to the Attorney General unless responsibility for the investigation is specifically assigned elsewhere by statute or the Attorney General specifically directs otherwise. Thus, the Department of Justice policy is a reiteration of statutory requirements.

The final decision as to who is in the best position, and has the best expertise, to develop the evidence in a case; determine when the case is sufficiently developed for prosecution; and determine whether a case is appropriate for prosecution will always, under the current statutory framework be the responsibility of the Department of Justice. However, it is the unique responsibility of the Inspector General to determine, from detection of criminal activities related to the Department's programs, where systemic weaknesses are which made the programs vulnerable to abuse. Thus, the Inspector General is responsible for taking action or making recommendations to reduce the incidence of crime in the department's programs.

Question 2. The intent of the Congress in establishing the Office of Inspector General was to provide for an independent and objective unit. For that reason, Congress provided for appointment of the IG by the President. As a practical matter it seems that the IG's appointments thus far have been pre-selected by the Secretary. Has the selection process affected your objectivity and independence?

Answer. No. As was pointed out at the hearing, two main reasons for my selection was a lack of exposure to the Washington environment and a knowledge of governmental fraud activities based on my years as an FBI agent. These factors coupled with the extensive White House investigation undertaken following the recommendation of my name to the President, the subsequent creation of the President's Council on Integrity and Efficiency and the President's emphasis on reducing fraud, abuse and waste in government, helps ensure that my objectivity and independence are maintained.

Question 3. Do you need full law enforcement powers?

Answer. The Office of Inspector General is already empowered to perform many functions of a law enforcement agency. Among other things our office can:

1. Subpoena records and documents (pursuant to 42 U.S.C. 3525(a)(3)).
2. Conduct electronic surveillance (pursuant to procedural requirements prescribed by the Department of Justice and, in the case of government telephones the General Services Administration).
3. Administer oaths to witnesses (pursuant to 5 U.S.C. 303(a)).
4. Request search warrants (pursuant to 28 Code of Federal Regulations Part 60).
5. Receive criminal justice information from other law enforcement agencies (pursuant to 28 CFR Part 20).
6. Request mail covers from the Postal Service (pursuant to 39 CFR 223.2).
7. Use unmarked government vehicles (pursuant to section 101-38.6 of the Federal Property Management Regulations).
8. Use undercover agents, pay informants, and pay for evidence (pursuant to 42 U.S.C. 3523(a)(1) and (a)(8)).

In addition, when a subject requests his criminal investigative file under the Privacy Act, the Office of Investigations can withhold information under "exemption (j)(2)" as a criminal law enforcement agency.

There is, however, a significant law enforcement authority we lack—the authority to carry firearms. For this reason, although we can request search and possible arrest warrants from court, the Department of Justice has apparently been reluctant to interpret 18 U.S.C. 3105 as permitting us to execute them. They have expressed concerns of what might occur in executing court orders without the physical means to enforce them. We believe that there are circumstances when have a firearm would be helpful. The Inspector General should be given the authority to permit agents to carry firearms when needed for their protection, for the protection of others, or to enable us safely to enforce an order of the U.S. District Court.

Question 4. In the upcoming budget resolution, OMB is insisting that payments to Medicare carriers and intermediaries for FY 1982 be reduced to $615 million or $115 less than the amount approved by both the House and Senate. Since many health cases are based on referrals from Medicare carriers and intermediaries, how will budget cuts, which reduce the ability of these contractors to identify abuses and suspected fraud, affect your investigations?

Answer. Although there may be wide variance among carriers in detecting fraud and abuse some of the problems were attributed to ineffective and inefficient use of available resources. Identification of abuses or suspected fraud, consequently, may not be affected drastically by budget cuts if more efficient use of computer screening and other detection skills are made by carriers and intermediaries.

Question 5. Do you believe it is wise to cut the budgets of intermediaries and carriers who are charged with the responsibility to identify fraud and abuse, as well as to audit providers of services? Or should we assure that payments to providers are appropriate and made in compliance with the limitations set both in the law and regulations?

Answer. I do not believe it is wise to reduce budgets of intermediaries and carriers especially in areas concerned with identifying fraud and abuse. I have already advised the Health Care Financing Administration of my position on cutting funding in this most important function.

The Medicare program reimburses hospitals and other providers their reasonable costs for providing medical care to program beneficiaries. Annual costs reported by providers are audited and paid by fiscal intermediaries under contract with HHS.

Statistics compiled from data reported by the intermediaries show, nationally, that provider audit is cost effective. A recent GAO report (HRD-81-84, dated April 24, 1981) pointed out that audits performed by intermediaries saved about $4 for every $1 spent over the last few years. This projects to a $200 million savings per year.

Provider audit has been, and in our opinion must continue to be, performed by Medicare intermediaries—these audits are the first line of defense against fraud and abuse. The OIG Audit Agency does not have the resources to assume the intermediaries' audit responsibilities. Although the Audit Agency has made several audits of providers' costs over the years, the Audit Agency's role has been, and should continue to be, to monitor the intermediaries' audit activities.

Carriers perform important functions in the areas of utilization fraud and post payment review which help identify fraud and abuse. Both the utilization review function and past payment review process require the use of practitioner payment history. Therefore, efficient implementation of these functions can be best handled by the carriers who accumulate this information on a day by day basis.

Consequently, as long as Medicare remains a cost reimbursable program, the need for provider audit will continue and any arrangement which provides an immediate 4 to 1 or greater return on investment is an excellent investment by most any standard. Further, it is reasonable to assume that unmeasurable additional returns are received from the deterrent effect of audit.

Question 6. How do you meet the legislative requirement for an annual report containing an evaluation of the performance of the Department of Justice in the prosecution of fraud and your recommendations for improvement?

Answer. In accordance with Public Law 94-505 and 95-142, the Office of Inspector General is required to publish annually a report summarizing our activities for the year, including statistics on Medicare and Medicaid cases referred to US Attorneys, Department of Justice. Those figures show indictments, convictions and declinations. What is not included, however, are the U.S. Attorney's reasons for declining a case. Some U.S. Attorneys have committed their time and resources to combatting other Federal violations. Others lack adequate staff or accept only cases with high dollar return potential. Whatever their reason, such non-related case factors impact directly upon our conviction rate statistics, resulting inappropriately in the establishment of askewed success/failure standard. This office is currently implementing a Civil Fraud Division within our Office of Investigations, which will identify those non-prosecuted criminal cases for appropriate civil or administrative sanctions. Once established, the statistics generated from this new effort will be balanced against our reports on cases referred to the Department of Justice, therey, illustrating more clearly our ongoing work load.

Question 7. According to your audit reports, questionable financial or management practices, cost disallowance recommendations and other conclusions and recommendations represent findings and opinions of the Audit Agency. The reports then state that final determinations will be made by operating division officials. What does that mean? Are the IG's findings tentative until program officials agree with them?

Answer. The IG's findings and recommendations are final, but are advisory in nature. Prior to issuance of final reports, the IG attempts to obtain agreement from program officials before issuance of significant reports. If agreement is not obtained, the IG will issue the report. Program heads are responsible for the resolution of audit findings and can deviate from the IG's recommendations.

However, follow-up audits are conducted to determine the adequacy of corrective action on prior recommendations. Where substantive recommendations have not been implemented, we bring these matters to the attention of: (1) the Audit Resolution Council chaired by the Under Secretary, (2) the Secretary, or (3) the Congress through my Quarterly Reports.

Question 8. How effectively are administrative sanctions applied to providers that abuse or defraud the health programs? Does your office determine whether administrative sanctions are in fact imposed?

Answer. Until the fall of 1981, this office did not track the results of its referrals to department components. Since that time, the Office of the General Counsel, Inspector General Division, has tracked the administrative sanctions imposed by components based upon referrals from this office. Currently, this tracking does not include sanctions applied due to reports or findings of abuse made by other components. Administrative sanctions applied in the Health programs are presently handled by the Office of Program Validation, Health Care Financing Administration.

As part of a realignment of functions within OIG, we are creating a division of Civil Fraud and Administrative Sanctions within the Office of Investigations. As presently planned, this division in cooperation with the Office of the Secretary, will initiate, develop, impose and monitor sanctions imposed by this department upon persons found in violation of program regulations, but whose case found non-prosecutable by the U.S. Attorney. During the initial stages of development, we will focus on OIG cases only. However, as additional resources become available, this division will have civil fraud and administrative sanction responsibility on a departmentwide basis.

Question 9. Provider audits, utilization reviews, the Medicaid Management Information System (MMIS), and other mechanisms to control abuse and identify potential fraud are spread throughout the department and its programs. What has the IG done to see that these mechanisms operate effectively? Should the IG be involved when these mechanisms are designed or updated?

Answer. Provider audits are included in our reviews of intermediary activities as mentioned in response to Question 5. Where deficiencies have been noted they were brought to the intermediary's (or carrier's) attention. Reviews of MMIS procurement practices and systems operations have been made in five States. Weaknesses noted were brought to the attention of both Department and State agency officials. In general, yes the IG should be involved when such mechanisms are designed or updated, but the ultimate responsibility for the implementation/updating rests with the grantee. Our revised organization and workplan will provide new emphasis to this area.

Question 10. Do operating division officials in fact make recoveries of monies lost to fraud and abuse? How effective is that effort?

Answer. Yes. Since 1978, the Department has maintained a system to control and account for audit disallowances. This system tracks the recovery of sustained audit disallowances through ultimate disposition. The audit disallowance system is part of the Department's overall Debt Collection activity and has been the subject of attention by the Congress, OMB, and the IG. For the period April 1, 1981 through June 30, 1981, some $28 million was collected as a result of audit disallowances. In addition, the Department has a cost savings program which Mr. Sermier has described.

Chairman DOLE. Thank you. I think we would like to hear from Mr. Anderson and then hear from the administration panel beginning at 2:30. But we would like to hear from Mr. Anderson, Director of the General Government Division, U.S. General Accounting Office at this time, unless it is inconvenient with members of the panel. So if that is satisfactory, we will hear Mr. Anderson and then reconvene the hearing at 2:30. So if the panel members would go have something to eat in the meantime, you will be fresh and ready to go.

STATEMENT OF WILLIAM J. ANDERSON, DIRECTOR, GENERAL GOVERNMENT DIVISION, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY MIKE BURNETT, AUDIT MANAGER, GENERAL GOVERNMENT DIVISION, AND ROD MILLER, HUMAN RESOURCES DIVISION

Mr. ANDERSON. Thank you very much, Mr. Chairman. I have a statement I would like to insert for the record, sir.

[The prepared statement follows:]

United States General Accounting Office
Washington, D.C. 20548

FOR RELEASE ON DELIVERY
Expected at 9:30 a.m., EST
Wednesday, December 9, 1981

STATEMENT OF
WILLIAM J. ANDERSON, DIRECTOR
GENERAL GOVERNMENT DIVISION
BEFORE THE
SENATE COMMITTEE ON FINANCE AND THE SPECIAL COMMITTEE ON AGING,
ON WAYS TO IMPROVE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES INSPECTOR GENERAL'S OPERATIONS AND RELATIONSHIP WITH THE FBI

Messrs. Chairmen and members of the committees, I am pleased to appear here today to discuss our review of the relationship between the FBI and the Inspectors General in investigating fraud against the Federal Government. We reviewed the investigative activities of Inspectors General at seven departments or agencies and their coordination with and relationship to the investigative activities of the FBI. However, as you requested, my testimony today focuses on the results of our work at the Office of the Inspector General (OIG) in the Department of Health and Human Services (HHS). Also, as you requested, my testimony includes information on the involvement of HHS's Health Care Financing

Administration (HCFA) in referring potential Medicare fraud cases to the OIG.

We identified five areas in which the Department's OIG operations could be improved. However, the first four of these areas were not unique to HHS. In fact, these problems existed in varying degrees at all seven Inspector General offices. Specifically, we found that:

(1) Coordinating the development of the Department's automated OIG management information system with other OIGs could improve the system and possibly save money.

(2) Sharing complete and timely information with the FBI could prevent duplicative investigative efforts and improve analysis of data on fraud cases.

(3) More thorough followup of case disposition and of recommendations for improved program control could better assure that fraud perpetrators are appropriately sanctioned, and that needed program changes are made to prevent fraud from recurring.

(4) Clarifying the OIG's investigative role could eliminate confusion, and improve accountability and fraud control efforts.

(5) Changing the present system of referring potential fraud cases from carriers through the HCFA regional offices to the OIG could facilitate the timely disposition of the cases, thus improving the carriers' chances to recover overpayments.

During our recently completed fieldwork, we also contacted 11 U.S. Attorney's Offices and other Department of Justice organizations to determine their role in coordinating and managing Federal fraud investigations. We plan to issue a report to the Congress on improvements that can be made in Federal investigative fraud control efforts. At HHS we focused primarily on the Office of Investigations in the OIG. We conducted work at HHS headquarters and three regional offices in Atlanta, Chicago, and Seattle.

Our findings concerning the role of HCFA in referring potential Medicare fraud cases come from a broader review of Medicare contractors' (carriers) activities. The work involved nine carriers under the jurisdiction of the HHS Atlanta, Boston, Chicago, and Philadelphia Regional Offices. We examined how carriers identify and prevent payment for unnecessary physicians' services and make recoveries where appropriate.

ESTABLISHMENT, ORGANIZATION, AND ACCOMPLISHMENTS OF THE OIG

Public Law 94-505, dated October 15, 1976, authorized the establishment of an OIG in the Department of Health, Education, and Welfare (HEW) to create an independent and objective unit which would, among other things, (1) conduct and supervise audits and investigations of HEW programs and operations, (2) provide leadership and coordination, and (3) recommend policies for activities to prevent and detect fraud and abuse in such programs and operations. On October 17, 1979, the President signed the "Department of Education Organization Act," which transferred to the new Department of Education most education programs from HEW and created an OIG in the new Department. That portion of HEW's OIG staff performing audits and investigations specifically related to these programs were also transferred. The remainder was redesignated the Department of Health and Human Services.

The Inspector General Act of 1978 (Public Law 95-452) dated October 12, 1978, authorized OIGs in 12 additional departments and agencies. On August 4, 1977, the Department of Energy Organization Act (Public Law 95-91) authorized an OIG in that Department, and on October 17, 1980, the Foreign Service Act of 1980 (Public Law 96-465) authorized an OIG for the State Department.

As of January 1981, the HHS OIG had the largest staff of auditors and investigators of all Inspector General organizations, but its investigative staff was the fourth largest. In addition to the Inspector General and his immediate staff, the OIG in HHS includes three groups--Audits, Investigations, and Health Care and Systems Review--each headed by a Senior Assistant or Assistant Inspector General. The Office of Investigations, headed by an Assistant Inspector General for Investigations, includes 4 headquarters divisions--Investigations, Training and Review; Investigative Systems; Special Assignments; and Security and Protection--11 field offices and 19 suboffices. At the end of fiscal year 1981, the Office had 123 investigators--111 in the field and 12 in headquarters. The OIG's annual report for calendar year 1980 states that, historically, OIG investigators have opened about 350 cases each year. Accomplishments cited in the same report included 137 indictments, 145 convictions, and $4.7 million in recoveries, fines, and restitutions.

In addition to the OIG, HCFA gets involved in Medicare-related fraud investigations. Prior to the 1976 Act which established the HHS OIG, Medicare fraud cases were usually investigated and referred for prosecution by the Office of Program Integrity within the Bureau of Health Insurance of the Social Security Administration. 1/ Since the OIG was established, several joint operating statements between HCFA and the OIG have made the OIG the focal point for investigating and referring fraud cases to prosecutors. However, these agreements have generally maintained HCFA as the initial contact point for referrals of potential fraud cases from Medicare carriers.

THE FBI ALSO INVESTIGATES HHS-RELATED CASES

In fiscal year 1980, the FBI opened 752 HHS-related fraud cases. Generally, these cases were opened on the basis of allegations from agency headquarters or local program staff, local FBI fraud hotlines, the news media, private citizens, or anonymous sources. Early in its investigation the FBI consults with a U.S. attorney concerning the case's prosecutability. If the U.S. attorney decides to prosecute the case, the FBI will work with the attorney and finish the investigation. If the U.S. attorney declines to prosecute, the FBI closes the case and refers it to HHS for appropriate action. For fiscal year 1980, the FBI reported that HHS-related investigations resulted in 130 indictments, 175 convictions, and about $2.5 million in fines and recoveries.

1/In March 1977, HCFA was established and the Bureau of Health Insurance including the Office of Program Integrity was transferred to the new organization.

INFORMATION SYSTEM DEVELOPMENT SHOULD BE COORDINATED

We reported in September 1978 1/ that one of the biggest weaknesses in Federal fraud control efforts had been the lack of information to measure the extent, location, patterns, and characteristics of the fraud problem. Only recently have the OIGs in all agencies begun to develop automated systems to obtain such information. Although some voluntary sharing of system design information occurs, most of the OIGs, including HHS, are developing these systems independently.

Our current review did not focus on the technical merits of any of these systems, but we did look at planned data collection elements, output formats, and estimated costs--all of which varied considerably. We recognize that information needs can vary because of differences in agency programs. However, we believe there is enough similarity of purpose among OIGs that coordination of their efforts to develop information systems could help assure similarity in (1) data gathered, (2) type of output, and (3) analysis performed. In addition, comparing computer equipment and software needed among all OIGs may indicate opportunities for cost savings.

Obviously, the OIGs are in the best position to determine their information gathering and analysis needs. By working together and sharing ideas, each could gain a better understanding as to what information is useful, and the OIG automated

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1/"Federal Agencies Can, And Should, Do More to Combat Fraud In Government Programs" (GGD-78-62, Sept. 19, 1978).

information systems could thus become a more valuable resource. Coordinating their efforts could help minimize differences in the type of data gathered and in the analyses of the data and could make each system capable of arraying data in similar formats. Comparable data could aid in evaluating the OIG's performance, help identify perpetrators of fraud across agency lines, and be used to compile more accurate Government-wide statistics on the fraud problem and the progress made toward controlling it.

Because of differences in past OIG annual and semiannual reports, meaningful comparisons of OIG results have been virtually impossible. A Department of Transportation OIG analysis of some recent Inspector General reports for 13 agencies showed differences in presentation or content for virtually every legislative reporting requirement. For example, Section 5 (a) (3) of the Inspector General Act of 1978 requires an identification of each significant recommendation described in previous semiannual reports on which corrective action has not been completed. The Transportation report states, in part, "Two of the thirteen [Inspectors General] * * * reported prior significant items in a separate chapter of the report, four included them in the chapter on 'Audit Activities,' and two presented the data as an appendix. [One] * * * made occasional reference to prior problem areas * * * but did not devote a separate section of the report to the matter. [HHS] * * * gave a general discussion of 'Unresolved Audit Reports Over Six Months Old' but did not list specific prior recommendations not yet implemented. In three reports we did not find any discussion of prior recommendations * * *."

Relatively large differences in cost estimates for the various OIG information systems hold out the possibility that some cost savings could be achieved if all the OIGs coordinated the development of these systems. HHS's latest cost estimate for information system development and implementation is $680,000, which is higher than the estimates for systems in other agencies--for example, $135,300 at the Department of Agriculture and $93,000 at Housing and Urban Development. Evaluating the whys and wherefores of the differences would require a detailed technical analysis that was beyond the scope of our work. However, such an analysis, including all the OIG systems, may show ways to economize or improve upon equipment and data processing capabilities that would not be clear to the OIGs individually.

IMPROVED INFORMATION SHARING WITH THE FBI NEEDED

Although some information sharing occurs, HHS and FBI investigators are usually unaware of what the other is doing. Moreover, neither HHS nor any of the other OIGs we reviewed included information on FBI fraud cases in their information systems. Thus, although some OIGs track FBI cases to assure appropriate action is taken, the thousands of Government fraud cases investigated by the FBI are excluded from any formal OIG analysis of the location, extent, characteristics, or patterns of fraud in an agency.

Informally, HHS investigators may call FBI investigators to find out whether the FBI is investigating a particular case, and the FBI occasionally will call HHS. This is sometimes the only, and certainly the most timely, information each agency has about the other's cases. HHS does not formally notify the FBI of open investigations. On the other hand, FBI procedures require its field offices to notify FBI headquarters by memorandum within 30 days of opening a case. In turn, FBI headquarters officials said these memos were forwarded to HHS headquarters. HHS headquarters then sends the memos to the appropriate HHS field location. An FBI headquarters official told us that field offices were actually allowed up to 60 days to send in the memos. One FBI field office official said his office does not send the notifying memos on cases that take less than 30 days to investigate. Thus, HHS field locations might not become aware of FBI investigations until long after a case is opened. Duplication of investigative effort is usually avoided because investigators of both agencies interview the same people at the start of a case and discover each other early in the investigation.

The FBI also sends each agency a memo at the end of its case investigations which describes the particulars of the investigation. The HHS OIG usually forwards these memos to the program office for possible administrative action and does nothing further with the information.

NEED FOR IMPROVED FOLLOWUP

The HHS OIG investigates primarily potential criminal matters. All others, including criminal cases that U.S. attorneys decline to prosecute, are referred to the appropriate HHS program office for action. The OIG does not systematically follow up on these referrals to determine whether appropriate administrative or civil actions are taken. This is especially important because most cases involving fraud against the Government are declined for prosecution. Similarly, although its investigators make recommendations for program changes to avoid recurrence of fraud, the OIG does not follow up with the program offices to determine whether the recommended changes are made. As we have testified on many occasions, fraud prevention activities such as improving program controls are the best way to control fraud against the Government.

HHS has one employee who tracks the most significant cases to conclusion, but for the most part case disposition is left to the program office and is not tracked. The HHS OIG was the only OIG we reviewed that normally does not investigate civil or administrative cases, but instead remands them to the relevant HHS program office. The HHS OIG also declines investigation of Medicare and Medicaid beneficiary fraud in favor of other HHS or State actions. FBI-investigated cases which have been declined for prosecution and referred back to the OIG are usually forwarded directly to the program office for action. Unless OIG staff are involved in a criminal prosecution, the OIG does not follow the case to determine whether all civil or administrative sanctions available are imposed. In some other agencies, cases are closed only when the OIG and program managers agree on the action to be taken.

We reported in May 1981 1/ that 61 percent of all cases that agencies referred for prosecution from October 1976 through March 1979 were declined. Therefore, civil or administrative action is the only action that will be taken on a majority of cases involving fraud against the Government. However, our May 1981 report also states that during the 2-1/2-year period covered by our review, agencies referred a total of 393 cases to the Department of Justice for civil legal action. The Department filed only 28 civil actions on these cases. In addition, as one agency official stated, getting program managers to take administrative action on cases declined for prosecution can be difficult. He said program managers sometimes assume that a declination means either the suspect was innocent or that the evidence was insufficient, and therefore they take no action. However, many cases are declined not for lack of evidence, but because (1) they lack jury appeal, (2) the dollar loss is considered insignificant, or (3) administrative action is considered more appropriate. The extent to which agencies take administrative action is the subject of another ongoing GAO review.

1/"Fraud In Government Programs:--How Extensive Is It?--How Can It Be Controlled?" (Volume 1, AFMD-81-57, May 7, 1981).

Since mid-1980, HHS has required its investigators to write Management Implication Reports on cases where their investigation reveals a management problem that should be corrected. The investigators suggest legislative or procedural changes to help prevent the fraud from recurring. The reports are sent to the OIG Health Care and Systems Review office in headquarters which finalizes the recommendations and sends them to the appropriate program offices. However, there is no followup to determine whether the suggested changes are made or to provide feedback on the results to the field investigator. Thus, the effectiveness of this procedure is uncertain. Again, in some other agencies, when investigators recommend program changes, the case is closed only when program managers and the OIG agree on the change to be made.

A CLEAR DEFINITION OF THE OIG INVESTIGATIVE ROLE IS NEEDED

Neither Inspector General legislation nor any other overall guidelines specifically delineate what the investigative role of an OIG should be. As a result, the Inspectors General operate their investigative offices in different ways, and established criteria against which to measure their effectiveness do not exist. As we mentioned previously, there is a lack of data on the extent and characteristics of the fraud problem against which to compare OIG accomplishments, and differences in data collection and analysis exist among the OIGs. These factors further complicate an analysis of OIG operations.

Although legislation concerning fraud against the Government requires OIG's to expeditiously report apparent criminal violations to the Attorney General, it does not specify which Federal agency has primary jurisdiction for criminal investigations. The FBI believes it does. Some OIGs agree, but most do not, including HHS. Little progress has been made between the FBI and the OIGs in negotiating comprehensive written agreements that would clarify their respective roles. The extent and quality of coordination between them has varied. Before the OIGs can be held accountable for their investigative results, and before the Federal Government can have unified and coordinated fraud investigations, the investigative role of the OIGs must be clearly defined.

Authorizing legislation is vague and comprehensive memoranda of understanding do not exist

HHS OIG legislation provides the OIG authority to request information and assistance from other Federal entities. However, neither OIG nor FBI legislation authorizing investigations of fraud against the Government provides specifics about how each should relate to the other. Although OIGs and the FBI have attempted to negotiate comprehensive memoranda of understanding that would more fully explain their relative roles and responsibilities, none have yet been completed.

The legislation establishing an OIG in HHS requires the OIG to supervise, coordinate and provide policy direction for investigations of fraud relating to HHS and its program operations. It also requires the OIG "to recommend policies for, and to conduct, supervise or coordinate relationships between the Department and other Federal agencies * * * with respect to (A) all matters relating to the promotion of economy and efficiency in the administration of, or the prevention and detection of fraud and abuse in, Department programs and operations * * * or (B) the identification and prosecution of participants in such fraud and abuse * * *." The legislation does not provide any specifics about the extent to which OIG investigators should investigate criminal fraud cases or about the relationship between the OIG and the FBI.

According to 28 U.S.C. 535, the FBI may investigate any fraud violation involving Government officers and employees despite any other provision of law. In addition, the FBI has authority and responsibility to investigate all criminal violations of Federal law not exclusively assigned to another Federal agency. FBI officials view OIG legislation as making no such exclusive assignment, and thus the FBI investigates cases involving fraud against the Government, including cases in each of the agencies having an OIG.

At the time of our fieldwork, HHS had a 1976 memorandum of understanding with the FBI concerning referral of quality cases as opposed to a large volume of routine recipient-type frauds. However, it had been used very little. As with all the other OIGs, no comprehensive agreement existed. In March 1981 the President's Council on Integrity and Efficiency was formed to coordinate and implement Government policies concerning integrity and efficiency in Federal programs. One of its first priorities was to negotiate such agreements between the FBI and the OIGs. However, FBI officials told us that the FBI should investigate criminal matters, and the role of the OIGs should be prevention and detection of fraud, not criminal investigations once fraud has been detected. On the other hand, OIGs are already investigating criminal cases and appear unwilling to give them to the FBI. Negotiations are still in process for these agreements. The estimated completion date for the first one is some time this week.

Some OIG investigative policies minimize the FBI's role

Lacking a clear role definition, the OIGs' investigative operations vary considerably depending on factors such as the philosophy of the Inspector General, caseload, and resources available. Some OIGs referred a majority of their cases to the FBI as soon as there was any indication that a crime had been committed. Others, like HHS, referred almost no cases to the FBI, preferring instead to work directly with the U.S. attorney through prosecution of the case. Still other OIGs investigated some cases and referred others according to their choice.

HHS OIG investigators generally do not refer cases to the FBI unless ordered to by a U.S. attorney or unless the FBI has primary jurisdiction, as in bribery cases. As stated previously, the HHS OIG investigates primarily potential criminal cases. Its investigators told us they usually contact a U.S. Attorney's Office early in their investigations to determine whether the case is prosecutable. If not, the investigators refer it to the appropriate program office for administrative or civil action.

HHS OIG regional offices are nearly autonomous in selecting cases to investigate; OIG special agents-in-charge may open and close cases at their discretion. One field office special agent-in-charge told us that his office needs and wants no help from the FBI except when there are too many cases for his agents to handle or when he lacks resources such as recording equipment. Both situations happen rarely, he said. Likewise, another OIG regional office special agent-in-charge said he rarely referred cases to the FBI and only when his region lacked sufficient staff to perform the investigations or when travel considerations precluded OIG involvement.

Extent and quality of coordination with the FBI varies

As mentioned previously, information sharing between the OIGs and the FBI should be improved. We found that the extent and effectiveness of other forms of coordination between these agencies varied depending on the individual investigator, agency, location, and the particular case under investigation. We believe that by looking long enough, almost any example of coordination--good or bad--could be found. For the most part, HHS OIG and FBI investigative activities are performed independently. Occasionally, they participate in a joint investigation, but we found very few of these, and they had usually been mandated by the U.S. Attorney's Office when both agencies were working the same case but failed to agree on which should take the lead. An

HHS regional OIG official told us that when both the FBI and OIG start an investigation on the same case, each wants the other to drop the case. We interviewed headquarters and regional officials of the OIG, FBI, and U.S. attorneys about the extent and effectiveness of coordination.

An HHS headquarters OIG official said cooperation with the FBI varies considerably depending upon the level of personnel involved, individual personalities, and office geographic location. The Assistant Inspector General for Investigations described the relationship with top FBI officials--the Executive Assistant Director of Investigations; Assistant Director, Criminal Investigation Division; and Director, White Collar Crime Section--as "very smooth" through formal and informal meetings and contacts about individual cases. However, he said he participated in a conference of several organizations involved in health care fraud investigations at which each entity seemed interested in protecting its own "turf," and he was discouraged by the FBI's position on the OIG's role in fraud control.

In one region, two HHS OIG investigators were participating with FBI investigators on a joint Medicare/Medicaid fraud task force directed by the Economic Crime Specialist in the U.S. Attorney's Office. Cooperation appeared to be good on both sides with each learning something from the other. Agents from each group participated in training seminars sponsored by the other. On the other hand, OIG agents in the same region said they felt they were treated less than equally by the FBI agents because of their lack of full law enforcement powers (search and seizure, carrying a gun, and arrest authority).

FBI and U.S. attorney personnel in another region said HHS OIG investigators are the least cooperative of all the agencies. A regional FBI memo to headquarters concerning the President's dismissal of all the Inspectors General stated that instead of cooperating with each other on investigations, the FBI and OIGs are in competition. FBI regional officials said their caseloads had decreased since the OIGs began work. According to an FBI study, this has occurred in several regions. Although FBI officials complain about the reduced caseload, an HHS OIG official in the same region told us that the FBI does not desire to investigate most HHS cases because the cases require too much effort. A lack of communication is evident in this region.

The extent to which OIGs conduct criminal investigations affects their entire organizations, including the number and qualifications of investigators, training requirements, and the extent of law enforcement powers needed. It also apparently affects the FBI's investigative caseload.

A recent Department of Justice policy directive may have the effect of unilaterally limiting the OIGs' investigative role. Under the new policy, OIGs are required to refer all potential criminal cases to the U.S. attorney and the FBI as soon as there is any indication a crime has been committed. The U.S. attorney, along with the FBI, will then decide who will investigate the case. This new policy will no doubt be unpopular with some of the

OIGs. Since it was not issued until our fieldwork was completed, we do not know what impact this change will have on the OIGs' investigative operations.

THE MEDICARE FRAUD REFERRAL PROCESS NEEDS TO BE CHANGED

The process of referring potential fraud cases from Medicare carriers through the HCFA regional offices to the OIG causes investigations to be delayed and carriers to lose the opportunity to recover overpayments. In addition, the number of convictions resulting from these investigations has consistently declined since this arrangement began. HCFA and OIG personnel agree that having both offices involved in the referral process has contributed to increases in the time investigations are in process, declines in the number of fraud convictions, and the loss of abuse overpayment recoveries.

Under the current operating agreement between HCFA and the OIG, HCFA is the initial contact point for referrals of potential fraud cases from the Medicare carriers. When HCFA has sufficient information to believe a strong potential for fraud exists, it is required to refer the cases to the OIG. According to HFCA and OIG personnel, problems occur because (1) the OIG investigates and presents Medicare fraud cases for prosecution without staff experienced in the extremely complex Medicare program, while experienced Medicare investigators have been retained in HCFA and (2) HCFA maintains an investigative function in addition to the OIG's which results in some duplication of effort.

Our review of 108 recently closed and open case referrals showed that the resolutions of potential fraud case referrals are lengthy. We reviewed 87 closed cases that had been referred to HCFA regional offices by eight Medicare carriers. These were taken from the carriers' lists of cases referred during 2-year periods between January 1, 1978, and September 30, 1980. In addition, we analyzed 21 referrals opened during that period that were still open at June 30, 1981, for 6 of the 8 carriers. Of the 87 closed cases, 31 were closed in less than 12 months; however, 34 were closed in 1 to 2 years, and 22 were closed over 2 years after the carriers' referrals. For the 21 open cases, only 1 had been in process less than 12 months, 8 had been in process from 1 to 2 years, and 12 for over 2 years. For 44 of these 108 cases we determined they were with HCFA an average of 8 months and with the OIG an average of 14 months.

Under HCFA instructions, carriers are not allowed to attempt to recover overpayments on cases where an OIG fraud investigation is in process because such an effort might jeopardize the OIG's case. Carrier officials told us about a number of cases where the opportunity to recover overpayments had been lost due to lengthy fraud investigations which resulted in no convictions. For example, a carrier suspected a podiatrist of fraudulently misrepresenting services and referred the case to HCFA in December 1977. In May 1979, a year and a half after receiving the case, HCFA referred it to the OIG. In July 1980, over 2-1/2 years after the case was initially referred to HCFA, it was declined for prosecution because of insufficient evidence and returned to the carrier for overpayment collection action. Although the carrier estimated that overpayments for services in excess of those actually performed totaled $9,700, it was able to recover only $2,535. Because of the 2-1/2 year time lapse, the carrier was no longer able to prove and recover the remaining overpayments totaling $7,165.

For fiscal year 1976, the last full year of HCFA's lead role in fraud investigation, the agency reported 83 Medicare fraud convictions. For 1980 and 1981, the OIG reported 19 and 15 Medicare fraud convictions respectively. OIG records show that none of the 87 closed cases included in our case review had resulted in Medicare convictions. According to both HCFA and OIG personnel, judgements about the prosecutability of these cases could be made much earlier in the investigative process.

We believe the present system of referring potential fraud cases should be changed. It is clear to us that one step in the process should be eliminated.

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In summary, changes in HHS' OIG operations could improve its information system, help assure that perpetrators of fraud receive appropriate punishment, improve its fraud prevention activities, and streamline its Medicare fraud referral process. However, without a specific definition of the respective investigative roles of the FBI and the OIGs, problems will continue to exist, and holding the OIGs accountable for their results as well as achieving a unified and coordinated Federal attack on fraud will be difficult.

Messrs. Chairmen, this concludes our prepared statement. We shall be happy to answer any questions that you or other members of the Committees might have.

Mr. ANDERSON. I will keep my comments short here. Let me start off by introducing the gentlemen at the table with me. On my left is Rod Miller. Rod is with GAO's Human Resources Division and the one that provides some health expertise here today. Mike Burnett is an audit manager in my own General Government Division. He's the one involved in the job that we are doing for your committee, sir, involving looking at the coordination between the FBI and Inspector Generals generally.

I would like to say that the Inspector General of HHS really touched upon some problem areas that we have identified and apparently he has recognized himself. It was gratifying to see that.

You had several items that you wanted us to talk about today. I will pick out the two most important and concentrate on them.

The first was the extent of cooperation and coordination between the FBI and HHS IG. I must say I was really gratified and surprised to hear Mr. Shuttleworth's comment that the local IG out there was so cooperative and, in fact, had shifted a case over to the FBI because that would be the exception rather than the rule. Perhaps it already reflects the changes that Mr. Kusserow was talking about.

But in the past, the FBI generally classified HHS as one of the least cooperative IG's that they had to deal with. HHS investigators that we spoke to out in their regional offices apparently only referred a case to the FBI as an absolute last resort. That seems a little incongruous given the shortage of resources that the IG has had to deal with, the limited number of investigators in the field. You would think they would take help wherever they could get it. They have not, in the past, been doing an effective job of drawing on the FBI.

I know you have seen the statistics in fiscal year 1980. There were more FBI convictions in health programs than in the IG shop; 175 versus 145.

In any event, it looks as though action is going to be taken in that direction under this particular Inspector General. The policy statement you spoke of earlier, if implemented the way Justice would like to see it, would apparently also de facto result in improved cooperation and more involvement of the FBI in the matters. And the Department of Justice has indicated it stands prepared to elevate this in the FBI's order of priorities. So I think that is a hopeful sign.

The only other item I will touch on involves the cooperation of HCFA's Office of Program Validation, Bureau of Quality Control and the Inspector General. Primarily I am referring here to the sharp dropoff in successful convictions involving medicaid and medicare fraud. Convictions went down from 83 in 1976, to 19 in 1979 and only 15 in 1980.

It is a fact that when the old Office of Program Integrity was responsible for pursuing these cases for prosecution, they apparently did a pretty good job. When that responsibility was passed to the Inspector General but the expertise still stayed back in the Bureau of Quality Control, problems have come up. I think everybody is willing to agree in both of those shops that it creates real problems having the prosecution responsibility on one side and the program expertise on the other side. There is a need to do something.

I will stop with those two important points, sir, and will try to answer any questions you may have.

Chairman DOLE. It may be in your statement which I haven't read carefully, but I am certain that the FBI does earmark some resources for medicare and medicaid investigations. Do they not?

Mr. ANDERSON. Yes, they do, sir. But I can't tell you how much. I can't even tell you, unfortunately, how many of those 175 convictions involved medicaid and medicare. However, the white collar crime area, which includes fraud against the Government, is one of the three top priority areas in the FBI—along with organized crime and foreign counterintelligence.

Chairman DOLE. Well, given your review and investigation, who do you believe should take the lead on investigation? The Inspector General or the FBI?

Mr. ANDERSON. I would say that with the arrangements that Justice proposes whereby the cases would be screened—looked at concurrently by the Department of Justice and by the FBI—if goodwill existed on everybody's part, we could probably make good decisions on individual cases. I think also that a mechanism that hasn't been used much in the past—joint task forces; there's one in Philadelphia now involving FBI, HHS, and some local folks—would appear to be an effective device to bring together the program knowledge of the HHS folks and the investigative expertise of the FBI. Also, perhaps there is room for the IG's to continue as they have in the past. I know they feel strongly that way. I know that the FBI has felt just as strongly that they ought to be out of the business totally. I think GAO kind of sits here unwilling on what it knows right now to take a firm position one side or the other.

Chairman DOLE. I—from the standpoint of the American taxpayer—would like to say that there has been some discussion that maybe there aren't enough resources available to the Inspector General—but that maybe they are not needed. That's the point that the Senator from Kansas wants to make.

If you have other agencies that have the resources and have the abilities, do we need to dress up another full-scale law enforcement agency and put in several hundred million dollars to compete with the FBI and other agencies. I think that's a matter of concern. Where we are concerned about fraud, abuse, and waste, we don't want to waste a lot of money in the process. It's not our money.

Mr. ANDERSON. Well, I know the FBI has about 7,500 or 7,700 agents. The figure is changing these days. But they have an awful lot of ground to cover. I don't think they are going to be able to put any large number of resources into this. They will make it a high priority, put more. But given the range of their responsibilities and 7,500 agents or so, I just don't know how far they are going to be able to go.

I think the point was very well made here this morning that the Inspector General really doesn't have a good fix on how many resources he needs. I know about another agency, the IRS, which has a taxpayer compliance measurement program. They can get a fix on the size of their problems and can decide the level of resources they should put into it. Similarly, the Drug Enforcement Administration is out there making their buys, getting quality information and price information.

We don't have it here. We really don't know. We don't have a fix on the size of the problem. Therefore, we really don't have a good basis to decide the resources we need to combat it.

I get the impression that the Inspector General saw that as a problem and intended to try and develop some information he could use to support a decision or a request for resources.

Chairman DOLE. Do either Mr. Miller or Mr. Burnett want to add anything to what Mr. Anderson said?

Mr. BURNETT. I might like to clarify a point about the assigning of resources specifically to medicare and medicaid investigations. If you are referring to allocating investigative resources to specific programs over a period of time, they do not do that. They do assign resources to task force type operations and that kind of thing—specific investigations—but they don't have a definite number or amount of resources——

Chairman DOLE. No allocations.

Mr. BURNETT [continuing]. Allocated to medicare and medicaid.

Mr. MILLER. I would just like to say that I think it is important to realize the source of the information that the FBI would be privy to in terms of what people are identified as either abusing or being fraudulent in the program. It's the program people who, in most cases, I think would come up with the greatest number of incidents of potentially fraudulent practices. So there is going to be a certain amount of effort extended on the part of program personnel whether it be within Health Care Financing Administration or whether it be within the OIG's office. Some of that activity and some of that work is still going to take place in order to develop good leads as to who is abusing or committing fraud in the program. So to merely give it to the FBI—I think perhaps they should be the end point at which full scale investigations are done. But the initiation of those cases, for the most part, are going to have to be done within the program.

Chairman DOLE. We will be submitting additional questions in writing.

[The questions follow:]

ANSWERS TO QUESTIONS FROM SENATOR DOLE

Question 1. In your experience, is our primary problem with respect to the Social Security Act programs (medicare, etc.). Waste? fraud? or abuse?

Answer. We confined our review primarily to government fraud investigations. However, our findings with respect to that problem, to the best of our knowledge, also apply to waste and abuse. That is, accurate estimates of the extent of waste, fraud and abuse in Social Security Act programs are essential to objectively answer you question. However, such estimates do not yet exist for these as well as other government programs. As stated in our testimony, this lack of information has been one of the biggest weaknesses in Federal efforts to control waste, fraud and abuse.

Inspectors General, including HHS's, are designing and implementing automated information systems that should soon begin to obtain better data on the extent of these problems. Our statement also discusses ways to improve those systems.

Question 2. Do you believe, based on your review of all the IGs, that the HHS IG should be given full law enforcement authority?

Answer. We did not specifically address this issue during our review. However, it is certainly a factor to be addressed in more clearly defining the relative roles of the IGs and the FBI. The extent of law enforcement authority needed by the IGs depends upon such considerations as (1) the extent and significance of fraud within the agency or its programs, (2) the extent of IG involvement in criminal investigations, (3) the availability of services from other law enforcement agencies, and (4) the extent of physical risks to IG investigators.

Chairman HEINZ. I would ask just one question. We have just been talking about what I might call "deterrents" which is finding someone who has done something bad, prosecuting them and putting them in jail just as long as you can. Particularly, if they are a provider. Most of this fraud can't take place without some help from a provider, usually a doctor.

But we have had some incredible testimony today about the lack of prevention. We had a witness, Dr. Kones, who tried to get caught. He had a system that just begged to be flagged, to be caught up with. In California, we saw people coming out day after day with shopping bags full of huge amounts of prescriptions.

Who should be held accountable in this system for prevention? Should it be the Inspector General? Should it be the Secretary of HHS? Should it be the Governor of California or his attorney general? Who should we hold accountable for prevention? I don't want to go through the frustrating experience, if it can be avoided, of coming back here a year and a half from now and having another set of witnesses who, for 6 years, have been parading around the United States or 18 months parading around the United States explaining how they tried to get caught but couldn't get themselves caught no matter to what extremes they went to. Who should be held accountable for designing and implementing the system so that these things I have just described don't take place?

Mr. ANDERSON. I think, Mr. Chairman, that the Congress, when they created the Office of IG, was looking to these people to do that sort of thing. I think the Congress has recently made the heads of Departments responsible for certifying as to the adequacy of internal control on all the internal financial transactions of the agency.

I think the IG's were expected to do that very same thing. And it gets back to what Mr. Kusserow spoke about. We have auditors over here who are supposed to be experts on internal controls. How do you set up a set of controls to stop or prevent rather than after the fact? The ideal marriage would seem to be to have investigators who can really identify what are the frauds that are being perpetrated out there, and then work with the auditors and try and decide how can we modify program controls to prevent this.

I guess what I am saying is I see the IG being the person with the resources to decide what needs to be done to set up effective controls up front. And it's just a case of proceeding to do it. In fact, there is a group within the IG shop here called the "Health Care Systems Review Group," which does have that responsibility under them. And has not done the job yet in behalf of HHS.

Chairman HEINZ. Now have you looked at the internal controls system in HHS?

Mr. ANDERSON. No, we have not, sir. In fact, the testimony that I bring here today is on a couple of GAO jobs in process that are not directly aimed at the subject of your concern today. So we don't have any ongoing work over there right now.

Chairman HEINZ. Is there any reason, other than perhaps the fact that you haven't been asked, that you could not take a look at the internal controls system in an agency such as HHS to determine whether it is or is not adequate?

Mr. ANDERSON. You are talking about the programmatic control, sir, over program funding. No. We, in fact, have done work like that in the past. We have ongoing work in other agencies. And if asked, the General Accounting Office certainly could go out and gage whether, in fact, they are doing what they can.

Chairman HEINZ. We may very well, and in short order, ask you to do that. I can think of a place you could start.

One last thing. I just want to clarify in your testimony whether there was an implication on your part that the FBI should be permitted to pursue all criminal cases to the exclusion of the Inspector General.

Mr. ANDERSON. No, sir. We did not mean to convey that.

Chairman HEINZ. So you believe the IG should do those tasks as well as the FBI?

Mr. ANDERSON. Yes, I would say for the present. I think there is enough work for everybody in this area. And given the resources the FBI can reasonably apply to it, you might as well have these people continue to contribute.

Chairman HEINZ. Well, Mr. Anderson, Mr. Miller, and Mr. Burnett, we thank you for being here. And the hearing will now stand adjourned until 2:30.

[Whereupon, at 1:11 p.m., the hearing was recessed.]

AFTERNOON SESSION

Chairman HEINZ. We are going to continue our hearing from this morning. At the outset, let me thank our afternoon witnesses for their patience. I sincerely apologize, but we went so long this morning because there was a lot of very important information to cover. Second, we are starting a little late right now because Senator Garn and other members of the Banking Committee, which includes myself, had a 2:30 engagement that we didn't have scheduled up until a few hours ago. So I hope all three of you that are here will bear with us in that regard.

Our three witnesses this afternoon are Mr. Martin Kappert, the Deputy Associate Administrator for Program Operations, at HCFA. Mr. Kappert is on my right.

The lights aren't quite as bright in here this afternoon as they were this morning, I am sorry to say.

Then we have Mr. Nelson Sabatini, Executive Assistant to the Commissioner of the Social Security Administration. And then Mr. Robert Sermier, Deputy Assistant Secretary for Management Analysis and Systems, Office of Management and Budget in HHS.

Gentlemen, we are pleased to have you here. Would you proceed?

Mr. SERMIER. Thank you, Mr. Chairman. With your permission, we would like to have our statements entered in the record and then abridge drastically our opening remarks.

Chairman HEINZ. Without objection, so ordered.

[The prepared statements follow:]

STATEMENT OF ROBERT F. SERMIER

DEPUTY ASSISTANT SECRETARY
FOR
MANAGEMENT ANALYSIS AND SYSTEMS

Messrs. Chairmen and Members of the Committees

Good Morning. I am pleased to appear before you at this joint hearing to discuss HHS' efforts to control fraud, abuse, and waste, and to respond to the three specific questions contained in your letter of invitation.

My written statement, previously submitted to the Committee, contains, in its appendices, specific responses to your first two questions. I will only highlight this information in my remarks, but am prepared to answer your questions for any of the individual IG reports and for any of the resource information I have provided. As requested, the information I have supplied addresses those reports for Departmental components other than the Social Security Administration (SSA) and the Health Care Financing Administration (HCFA).

In your first question, you asked for a description of the actions the Department has taken in response to certain recommendations made by the IG during 1980.

For the five relevant audit reports, I am pleased to report that the involved Departmental components have completed all but two of the eighteen major recommendations made by the Inspector General (IG). The exceptions relate to the IG's recommendations that HHS conduct on-site financial reviews for all recipients of HHS funds, and that HHS clarify its definition of consultant services. We have not implemented the first change because we have chosen to concentrate our on-site review efforts upon those entities which expend the largest amount of funds and thus have the highest potential payback for resources expended. For the second recommendation, we agree fully with the IG and will continue to attempt to reconcile the differing definitions of consultant services imposed upon us by the Office of Management and Budget and our Senate Appropriations Sub-Committee.

For the four Service Delivery Assessments (SDAs), I cannot be as conclusive primarily because of the nature of SDAs. As you may know, SDAs are designed to provide the Secretary with information on subject areas primarily from the perspective of the clients who receive these services or the perspective of Federal, State or local workers who provide the services. They are done relatively quickly (3-4 months) and are not intended to have the statistical or analytical rigor of an audit or formal program evaluation study. The purpose of an SDA is to provide to the Secretary one form of input (a grass-roots view of a program) for consideration in policy making. The regional analysts who perform SDAs do make recommendations, but the Secretary decides what, if any, actions will be taken.

For the four relevant SDAs you cited in your letter, either former Secretary Harris or Secretary Schweiker received the IG's report on the SDA. The Department has initiated specific actions related to all four SDAs and these actions are described in material appended to my written statement. There are some actions which we have not completed due either to the shift in program management strategy to the Block Grant concept, changes in resource allocation priorities, or, in one case, the need to await the awarding and completion of a contract for external technical assistance. I am prepared to discuss each SDA in response to your questions.

Your second question dealt with what other activities, beyond those of the Inspector General, the Department was taking to combat fraud, abuse, and waste and the amount of resources devoted to these activities. In response to the latter part of this question, I have submitted, in Appendix II to this statement, a series of charts which lists the units, personnel, and dollars involved in such activities. These units perform studies and reviews which examine financial transactions, accounts and reports; compliance with applicable laws and regulations; our use of staff and physical resources; and whether we are achieving our expected goals and objectives.

I wish to stress that, in developing these charts, we have adopted the broadest possible definition of studies or reviews which could be involved in identifying fraudulent, abusive, or wasteful activities. Thus we have also included staff resources devoted to operating quality control systems (which detect errors in our large income maintenance and health care financing programs) and other staff who carry out, on a full-time basis, management analysis and program evaluation activities directly aimed at identifying wasteful practices in our internal operations. Finally, we have also included staffing data for personnel in SSA who carry out reviews of various types of claims. These staff do not carry out formal audits or specific investigations as the Inspector General does, but they do carry out efforts designed to avoid errors or waste.

Because the data identify resources devoted to carrying out analytical, review, or investigative functions, the data do understate the Department's overall level of effort by excluding staff involved in other operational activities which contribute significantly in combatting fraud, abuse, and particularly waste. As examples, program managers with a basic responsibility for ensuring the efficient operation of their programs, program staffs who implement management procedures and controls to reduce waste, and management staffs who monitor the effectiveness and efficiency of program operations on a continuing basis, are not included in the staffing charts.

I also wish to note that Secretary Schweiker has directed the Office of the Assistant Secretary for Management and Budget to conduct a Department-wide study to identify possible overlaps or duplication between the activities of the Inspector General and related activities carried out by our operating divisions, such as HCFA and SSA.

Using our definition of activities devoted to fighting fraud, abuse, and waste, as the charts indicate, the Department has 42 units outside of SSA involved in these efforts. SSA has more than 1,300 units, including its district offices, involved in these efforts. The Department has estimated 10,115 people assigned to the various functions related to reducing fraud, abuse, and waste. Our efforts had a combined cost of approximately $336 million in FY 81. This cost includes salaries and expenses for personnel, and other major administrative expenses such as the costs of operating our quality control systems.

Attached to the charts is a description of the major functions of the various units listed in the charts, and, I and my colleagues would be pleased, in response to your questions, to discuss the specific functions of various units.

To complete my response to your second question, the Department has underway or will soon initiate a number of Department-wide efforts related to fraud, abuse, and waste. I would like to briefly describe five of these major efforts.

- The Department's Savings Program

  Since FY 1979, the Department has had a major program to improve operational efficiency and to eliminate instances of fraud and abuse. Through the program, we identify problem areas, devise corrective actions, measure changes resulting from these corrective actions and document savings based on the changes. Under this program, we count as savings those situations where we avoid spending monies improperly or unnecessarily because of new or improved management actions or where we recover monies owed the government, through repayment or adjustments to future payments. Savings activities by the HCFA and SSA constitute the majority of our annual documented savings. Activities by the IG are also included in the Savings Program. Examples of the types of individual savings efforts which are in the program include: intensifying our audit and criminal investigation efforts, working with

Medicare contractors to process Medicare claims more efficiently, identifying inappropriate claims of Medicaid costs, removing ineligible students from the Social Security benefit rolls, lowering the payment error rates in the Supplemental Security Income, Medicaid and Aid to Families with Dependent Children programs, and improving our acquisition of information systems. In FY 1979 and FY 1980, we documented savings of approximately $1.4 billion in each of the fiscal years.

- Debt Management Project

For the past three years, we have had a project underway to improve the Department's overall performance in collecting debts. These collections include both audit disallowances identified by the Inspector General, and other debts owed by the public from such sources as scholarships, loans, and overpayments under entitlement programs. An aggressive debt management program reduces the probability of recurrence of debts and debts going unpaid. Active collection returns needed funds to the Federal Treasury, thus reducing the Treasury's borrowing costs.

We have collected approximately $224 million out of the $468 million in audit disallowances identified since October 1978. Debts owed by individuals far exceed this total. Since December 1980, we have collected $2.5 billion out of an estimated $5.5 billion owed to the Department. Of the $3.0 billion debt currently owed the Department, $1.9 billion is in SSA programs and $.9 billion in Public Health Service programs. Of the $3.0 billion total, we estimate that 19% of the debt ($570 million) is over 1 year old.

- Cash Management

In this area, we have pursued activities to improve our control over the use of Federal funds. During fiscal years 1980 and 1981, letters were sent to the Governors of the thirty largest recipient States announcing that HHS would implement one of two procedures (either a checks-paid or delay-of-drawdown letter of credit) for Federal financing of the Public Assistance programs. Under these procedures, HHS provides funds to the States in accordance with their pattern of expenditures rather than providing a lump sum payment at the beginning of the month. We have been successful in completing our implementation of the delay-of-drawdown procedure in sixteen of the thirty States, achieving savings of $214 million, in FY 81 budget outlays. We have achieved additional FY 81 budget outlay savings of $97 million in six other States by enforcing proper cash management procedures under existing letters of credit. We have been delayed in implementing delay-of-drawdown procedures in these latter six States and eight other States of the thirty States, principally because of currently existing State constitutional or statutory restrictions which prevent the States from agreeing to operate under the requirements of the delay-of-drawdown procedure.

- Making Management Efficiency a Part of Performance Appraisal

For FY 1982, the Secretary has requested that managers throughout the Department include in their performance appraisal plans at least one objective which addresses improvements in operating efficiency. We expect to realize improvements in operations through this approach and also to raise further the consciousness of our managers of the need for increased efficiency in all our activities.

o Increased Emphasis on Audit Follow-Up Activities

Within the last year, Secretary Schweiker has established a series of procedures which will help the Department deal much more systematically with information originating from the Office of the Inspector General. As an example, senior managers throughout the Department are now held more directly responsible for resolving all monetary audit findings within the six-month time period mandated by statute. The Assistant Secretary for Management and Budget receives monthly reports on agencies' performance in resolving their monetary audits. When it appears that an audit will not be resolved in the six-month timeframe, this triggers a meeting of the Department's Audit Resolution Council, made up of the Under Secretary and other senior officials in the Department. Managers are also responsible for collecting audit disallowances in a timely manner and implementing corrective actions to procedural problems identified through GAO reports and Inspector General audits. Through our new procedures, the Secretary monitors managers' performance in these three areas on a continuous basis. We believe these actions considerably strengthen our efforts to curb fraud, abuse and waste by requiring managers to give greater attention to completing follow-up actions, both monetary and non-monetary, which flow from the reports and audits of the IG and GAO.

Your final question asked for specific or general examples which illustrate the impact the Office of the Inspector General has had upon the Department's efforts to stem fraud, abuse, and waste. The IG's annual reports describe in detail the large amounts of funds ($97 million in calendar year 1980) which auditors identify for recovery, and the numerous convictions and sanctions which the IG's investigators, together with the Department of Justice, obtain each year. These activities are public knowledge, and it is not necessary to recite here these contributions.

The presence of the Office of Inspector General has also created a heightened awareness on the part of managers throughout the Department of the need to manage programs as efficiently as possible, with particular emphasis on the financial aspects of program operations. The Inspector General has made all managers throughout the Department far more aware of specific problems of fraud, abuse, and waste and the dimensions of these problems. The reports of the Inspector General are used as a primary basis for the Department's continuing formal program to combat fraud, abuse, and waste.

As an independent organization with direct access to the Secretary, the Office of the Inspector General has, since its inception, provided continuous third party assessments to our managers which have identified problem areas requiring Departmental attention. Following studies by the IG which indicated a need for improvements in completing audit follow-up activities, programs have begun to initiate aggressive campaigns to collect audit disallowances and make certain that recipients and grantees implement appropriate corrective actions. Completing these audit follow-up actions, in effect, use the audit to its fullest. We expect that these actions will also indicate to recipients and grantees that the Department will no longer permit the continuation of inefficient and/or improper activities.

The IG has played a lead role in a number of analytical efforts to identify instance of fraud and abuse that involve more than one of our major organizations. These "cross cutting" efforts include such activities as Project Match and Project Integrity, which involved the use of the computer to match and analyze large data bases. Where these efforts identify initial matches, the IG and the involved organizations work closely together in conducting joint follow-up investigations.

Finally, the Office of the Inspector General has provided the Department with an additional conscience. While we believe that the overwhelming majority of Federal employees, grantees, and recipients are completely honest, and GAO reports and the IG studies tend to confirm this contention, nevertheless, we also believe that the presence and the investigative activities of the Office of the Inspector General have provided an additional deterrent to fraud and abuse in Federal programs.

APPENDIX I

Summary of Departmental Actions (Other Than SSA and HCFA Responses) to Specific Recommendations Made By HHS Inspector General (IG) in 1980

The following information summarizes Departmental actions taken in response to recommendations and findings made by HHS' Inspector General in 1980 for those specific audits and memoranda listed by the Committees.

IG Report on the Runaway Youth Program
October 1979

SCOPE

This report was based on a review of the Runaway Youth Program operations and an audit of the program's grants and contracts process. The review was requested by the Secretary.

RECOMMENDATIONS

(1) The Runaway Youth Program's policies needed to be clarified and made consistent with related policies in other programs (i.e., 15-day limitation placed on services to youth in runaway shelters was inconsistent with 30-day limitation placed on room and board requirements under Title XX).

(2) Fiscal monitoring by the program required improvement. Improvements were also needed in assessing grantee performance and providing technical assistance.

(3) The implementation of the Runaway Youth Program's Management Information System was a major problem and the Department needed to give greater priority to the development of the system.

(4) The grant award process for the program lacked clear and timely instructions. Staffing was insufficient and training was required.

CORRECTIVE ACTIONS

(1) A Regional liaison position was established to improve communications to the Regions and grantees on policy issues. The Department also published a Program Information memorandum in the Federal Register. In addition, the program has recommended the withdrawal of the 15-day limitation requirement in its regulation.

(2) The Department has issued revised and more uniform audit requirements for fiscal monitoring. Fiscal management staff have received training and have made site visits to grantees as part of their monitoring activities.

(3) The Management Information System is now operational and quarterly information on runaways is now available.

(4) The procedures for the grant award process were revised and regional office staff have received additional training.

IG Audit -- Memorandum to General Counsel Regarding Cost Disclosure Requirements of Consultant Services Contracts

SCOPE

The purpose of this review of Consultant Services contracts was to determine whether contracts included disclosure statements of costs and names of personnel responsible for preparing reports under the contract (other than routine progress reports).

The review focused primarily on 55 contracts active in FY 1979.

RECOMMENDATIONS

The IG found that the Department was not complying with the requirement to obtain disclosure statements of costs and names of personnel associated with the preparation of reports under consultant services contracts.

That the Department improve compliance with this requirement by:

- revising its regulation to make the disclosure statement of costs and names of personnel responsible for preparing reports applicable to all reports under a consultant services contract (i.e., progress and draft reports).
- providing additional clarification and guidance as to what constitutes a "consultant contract."

CORRECTIVE ACTIONS

The Department has taken the following corrective actions:

- revised its regulations to require that the cover of every report under a consultant service contract include the following standard information: (a) name and business address of the contractor; (b) contract number; (c) contract dollar amount; (d) whether the contract was competitively or non-competitively awarded; (e) name of the Department's project officer and office identification; and (f) names of managerial and professional staff.
- communicated the expanded requirement to responsible Department officials and directed that they assure appropriate officials are aware of the new rule.

These actions were taken in response to an OMB directive issued in July 1980 which was part of an overall Federal effort to improve the Government's use and administration of consultant services contracts.

With respect to the recommendation to provide guidance to clarify what constitutes consultant services contracts, the Department has had some problems in this area. We are currently operating under two definitions -- one required by OMB Circular A-120 and one required by Congress and included in the Department's General Administration Manual (chapter 8-15). We have not yet been successful in our attempts to reach agreement with the Senate Labor/HHS/Education Appropriations Subcommittee to allow us to revise the Department's current definition (GAM 8-15) to coincide with OMB's definition.

The Department has undertaken several steps to improve its management of contracts, including annual scheduling to prevent excessive year-end spending and requiring approval by the Assistant Secretary for Management and Budget of all non-evaluation consultant services contracts in excess of $100,000. (The Assistant Secretary for Planning and Evaluation reviews and approves virtually all evaluation contracts.)

IG Audit -- Review of Cash Management Practices
Departmental Federal Assistance Financing System (DFAFS)

SCOPE

The review was directed primarily at determining the effectiveness of DFAFS' procedures and recipients' accounting systems in limiting cash withdrawals to their immediate needs.

The audit generally covered the period July 1978 to June 1979. However, since the Department established new procedures in December 1978 to improve DFAFS controls, the primary thrust of the audit report was on those major weaknesses which persisted after the new procedures were implemented.

RECOMMENDATIONS

That the Department strengthen its procedures for reviewing recipients' cash balances by:

- Following-up promptly to recover excess cash from recipients identified as having excessive cash balances and to limit recipients' future withdrawals to their immediate needs.
- Providing for cyclical visits to recipients' sites to identify recipients that maintain excessive balances during the quarter but not at the end of the quarterly reporting period.
- Increasing the number of low-dollar recipients included in the sample for quarterly review.
- Screening the low-dollar universe to identify high risk recipients (e.g., recipients who withdraw cash infrequently, such as every 3 to 6 months, which probably therefore have Federal cash balances in excess of their immediate needs).

CORRECTIVE ACTIONS

The Department has taken the following corrective actions:

- Assigned a higher priority to recipients with larger accounts and established a special administrative section to monitor these accounts to assure recipients report accurately and timely, do not have excess cash balances, and take necessary corrective actions.

- Developed an automated recipient dunning letter process which scans all recipient accounts (large and small) and identifies recipients which appear to have excess cash and others who are delinquent in submitting expenditure reports.

- Implemented, in conjunction with Treasury, a pilot project -- electronic funds transfer (EFT) -- which provides funds to recipients on a timely basis, thus making it easier for recipients to delay drawing funds until the funds are actually needed. This procedure also makes each request for cash subject to Departmental review.

- Worked with States to implement delay-of-drawdown procedures for Public Assistance programs. Sixteen States have now converted to the delay-of-drawdown system.

With regard to the recommendation to provide cyclical visits to recipients, the Department requested 16 additional positions in the President's FY 1982 budget for the General Departmental Management (GDM) Appropriation. House action on the FY 1982 appropriations bill specifically deleted funds related to this request. In addition, the 12 percent reduction recommended by the President in September in discretionary programs affects the GDM Appropriation. The Department has continued to concentrate its efforts on States where the payback is greatest for the resources expended.

IG Audit -- Review of Internal Controls Over Payment of Overtime in the Department of Health and Human Services

SCOPE

The primary purpose of the review was to determine if overtime was adequately controlled and accounted for, and overtime payments were accurate throughout the Department.

RECOMMENDATIONS

That the Department improve its controls and procedures for overtime in the following areas:

- overtime requests and authorizations;
- documentation for overtime worked;
- separation of duties; and
- time and attendance (T&A) Reporting.

CORRECTIVE ACTIONS

The Department has initiated a number of actions to strengthen controls on overtime accounting including:

- issuance of a comprehensive self-training manual for timekeepers including periodic certification of timekeepers' proficiency;
- issuance of four personnel instructions in the areas of "work at home," "overtime pay-Federal wage system," "premium pay," and "recording overtime worked;"
- auditing twice as many T&A reports per pay period to identify agency deficiencies and establish targets for reduction of errors;
- issuance of a circular which individual units are required to use to assess their overtime procedures as part of an overall personnel administrative evaluation; and
- elimination of "at home" overtime, except with the prior approval of the Assistant Secretary for Personnel.

IG Audit -- Review of the Department of Health and Human Services (HHS) Implementation of the Energy Conservation Program

SCOPE

The review was made to determine how well the Department was carrying out Presidential and Departmental directives to conserve energy.

RECOMMENDATIONS

The review showed that, although energy reductions were achieved, significant additional reductions were possible in HHS-occupied buildings.

The IG's review included a number of specific recommendations to improve the Department's energy conservation efforts such as:

- reemphasizing administrative responsibilities for energy conservation;
- conducting periodic energy surveys;
- taking specific actions to reduce unnecessary energy uses; and
- giving high priority to projects which demonstrate energy conservation potential.

CORRECTIVE ACTIONS

The Department has undertaken several actions to further energy conservation:

- conducted Energy Management Seminars to brief facilities managers on all current energy-related requirements; included chapter on energy conservation in the Facilities Engineering and Construction (FEC) Manual;
- conducted approximately 100 installation surveys to assess opportunities for conservation and have developed corrective action plans;
- modified one-third of the National Institute of Health (NIH) Bethesda campus buildings to improve energy conservation; engaged janitorial services performed in the daytime to conserve on nightime lighting; and
- budgeted $400,000 in FY 82 for two projects to demonstrate cost/effective energy conservation activities (i.e., surveys of Indian Health Service (IHS) facilities and a waste-heat recovery project at the Center for Disease Control (CDC)).

Service Delivery Assessments

The Committees listed nine Service Delivery Assessments (SDAs) provided to the Secretary in 1980. Four of these SDAs dealt with programs not administered by either HCFA or SSA.

OVERVIEW

SDAs are short-term studies of HHS programs and services conducted at the local service delivery level. These assessments are not designed to be statistically valid research studies, compliance reviews, audits, program monitoring activities, or traditional program evaluations. Rather, an SDA consists of gathering current qualitative information from open-ended discussions with clients and service providers. The knowledge gathered is subjective in nature and is intended as a way for senior-level HHS personnel to obtain the views of the people most directly affected by HHS programs. Assessment results are meant to be used internally by Department managers as an additional source of information on service delivery which, when combined with other program data, provide a more complete picture of program operations.

DISCUSSION OF SPECIFIC SDAs

1. PHS Community Health Centers (CHC)

Description

The purpose of this SDA was to examine how users perceived the quality, accessibility, and responsiveness of CHC services, as well as the effectiveness of Centers in enrolling members of their communities for continuing care and linking patients to other community services. The SDA observations were made after interviewing 829 persons: 493 health care consumers, 58 project administrators, 104 medical staff, 77 Board members, 82 other institutional and private providers of health care, and 15 State and local officials.

Major Observations and Related Departmental Actions

- Coordination of services with other providers, at least on a formal basis, was not greatly in evidence.

  The FY 82 budget is expected to reduce the scope of services offered. Ancillary activities, such as referral, are expected to be of a lower priority than the delivery of basic health services.

- The sliding fee scale (SFS), tends to be down-played by some centers.

The Bureau of Community Health Centers (BCHS) has this past summer issued a policy memorandum on financial management, as a result of this SDA and a related GAO report. The policy states that Centers should establish a fee schedule, including a sliding fee scale, and Centers should implement effective billing and collection procedures for third party reimbursement.

- Many Administrators and Board members stated that training and technical assistance from HHS Regional Offices was inadequate.

  The Department expects a 50% loss or turnover in regional personnel, which will result in fewer and less experienced personnel available to provide training and technical assistance.

- Some CHC administrators experienced a dilemma between the need for financial self-sufficiency vs. service to the most needy. This dilemma affects the aggressiveness of their outreach to particular client types.

  Over time, BCHS has acknowledged that the financial self-sufficiency concept was an unrealistic objective for CHCs, given current health financing resources. In light of the FY 82 budget, BCHS has deemphasized the concept of self-sufficiency and will concentrate its funds on projects in the most underserved areas and on the provision of basic health services.

2. Health and Social Services to Public Housing Residents

Description

The assessment examined the cooperative health and social service programs aimed at meeting the needs of public housing residents. The assessment focused on the following areas: 1) the types of health and social services provided to public housing residents; 2) the extent of the involvement of public housing residents in determining the types of services provided; 3) whether some housing projects received more health and social services than other projects within the same local housing authority; 4) the extent of coordination among provider agencies serving the project; and 5) the impact of the joint HHS/HUD Public Housing Urban Initiative Program on the provision of services.

During the assessment, 580 respondents were contacted which included 314 public housing residents, 107 health and social services providers, 33 project tenant council leaders, 111 housing management staff, and 15 HUD personnel.

Major Observations

- The most commonly used services were health, income maintenance, transportation, prenatal and child health, and services to the elderly. Most residents were not well informed on how to obtain available and needed health and social services if they had not previously used the service.
- Residents were not often involved in the decisions regarding the kinds of services available to them and there was a lack of coordination in the delivery of services among some providers.
- Several factors had a negative influence on the delivery of services:
  - Fear of crime prevented residents from leaving, and providers from entering, projects;
  - Transportation and outreach/home visits to residents were limited.
- Some public housing projects received more services than others as a result of their location, strong tenant councils, and a high population of elderly residents.

Related Departmental Actions

The Secretary used the information presented in the SDA as the basis for initiating efforts to improve the delivery of health and social services to the residents of public housing projects. Four exemplary human services delivery systems in public housing projects were chosen. Site visits were made to these projects in order to gather information and then descriptions of these health and social service delivery systems were developed.

3. Title XX

Description

This assessment examined a number of aspects under Title XX: 1) the resource allocation processes used by States; 2) the nature and composition of the local service delivery systems; 3) the experience of eligible recipients of Title XX social service programs; and 4) the efforts of the Department and States to coordinate the delivery of human services.

Information was gathered from 16 sites in 8 States. Those interviewed included 272 clients of Title XX programs, 46 client advocacy groups, 40 State officials including Governors' and legislative staffs, 29 local Title XX administrators, and 107 provider agency administrators.

Major Observations

- The resource allocation process in most States seemed highly political and was influenced by State legislators. The State officials viewed Title XX as a funding mechanism, not a program.

- The service delivery systems used in States were complex mixes of providers using Federal, State, local, and private funds. A few agencies indicated that they were unable to identify who received their services. Some eligible recipients seeking services (i.e., the deinstitutionalized, the elderly) went unserved.

- The purchase of service (POS) contract was the perferred method for providing services by States, but the renewal of the same contracts limited competition. States gave low priority to monitoring POS contracts. Many agencies disregarded regulations restricting private donations to help pay State matching funds.

- Many of the clients indicated that the services they received were beneficial. However, the working poor were often unable to meet State eligibility requirements.

- The Department had not provided leadership in coordinating existing services at the State and local levels and had not provided needed technical assistance.

Related Departmental Actions

Title XX is now part of the Social Service Block Grant which will provide greater flexibility at the State and local level for planning social services activities. As a result of the SDA finding concerning technical assistance, the Department is developing a new stategy to improve the technical assistance provided to States under the block grant. This strategy recognizes that States have control over the funding of discretionary projects but attempts to coordinate similar projects within States in order develop data desired by the projects for the minimum cost.

4. PHS National Health Service Corps (NHSC)

Description

The purpose of this SDA was to examine: 1) the quality of NHSC services received by health manpower shortage areas (HMSA); 2) the impact on local health care for those manpower shortage areas without Corps assignees; and 3) the characteristics of areas unable to recruit or retain Corps staff.

The following SDA observations were based on interviews with 67 NHSC staff, 153 non-NHSC site staff, 89 Board members, 11 private physicians, 10 public officials, and 200 consumers.

Major Observations and Related Departmental Actions

- The ease with which Corps vacancies are filled appears to vary based on climatic, topographic, and economic conditions, and the degree of geographic isolation.

  This variation in filling vacancies is expected to continue since the size of the Corps is not sufficient to fill all vacancies. In addition, the program office believes it would be a disservice to communities to "force place" Corps doctors in locations where they do not want to go. Preference of the professional is balanced against placement in the highest-need areas.

- The scholarship program was criticized by some Corps staff and communities.

  In the past year, scholarship recipients were offered the opportunity to serve internships in rural settings during summers to ease their adjustment to the service obligation. In addition, regional officials are now expected to contact every scholarship recipient once a year to acquaint them with expectations of the Corps.

  The legislative requirement which gives scholarship priority to first year medical students was criticized because individuals considered this timing too early in the educational program for a student to make an informed commitment to a particular residency specialty or to the Corps.

- In some communities conflicts arose between private providers and Corps assignees.

  This past year the NHSC issued a policy requesting that the local professional medical society comment whenever an area comes up for designation as a NHSC site. Also, when a Corps designee chooses a community in which to locate, the designee is instructed to meet with the local medical society. Finally, DHHS will sign a contract with the American Medical Association to have the AMA assist in the identification of vacancies in shortage areas, in placement of Corps staff, and in resolution of conflicts between Corps and private providers.

Resources Used in Addressing Fraud, Abuse and Waste FY 81

AGENCY	# OF UNITS	Staff PROFESSIONAL	 SUPPORT	 TOTAL	FUNDS ($000)
Health Care Financing Administration (HCFA)	16*	-	-	749	$ 27,713
Social Security Administration (SSA)	**	-	-	9145	301,400
Public Health Service (PHS)	12	67.75	14.8	82.55	2,466
Human Development Services (HDS)	5	68.5	21	89.5	2,725
Office of the Secretary (OS)	7	42.1	7.5	49.6	1,834
TOTALS	42**			10,115.65	$336,138

* HCFA provided resource data by type of activity. However, these activities are concentrated in 6 headquarters offices and 10 regional offices.

** Information on SSA's resources used for fraud, abuse and waste was only available by type of activity. However, because many of these activities are carried out by SSA's 1300 district offices, we have not included SSA units for comparison purposes.

Resources Used in Addressing Fraud, Abuse and Waste FY 81

HCFA	ACTIVITY	COMPONENT	F/A/W*	STAFF TOTAL	FUNDS ($000)
	OPERATIONS				
	Medicaid Management Infor. System (MMIS)	Central staffs, field offices	A & W	31	$ 1,147
	Medicaid Quality Control (MQC)	Central staffs, field offices	W	163	6,031
	Cost Report Evaluation Program (CREP)	Central staffs, field offices	A & W	56	2,072
	Part B Quality Assurance Program	Central staffs, field offices	W	37	1,369
	Validation Review Program	Central staffs, field offices	A & W	126	4,662
	Assessment of Medicare Contractor & Medicaid State Agency Performance	Central staffs, field offices	W	277	10,249
	Abuse Investigation	Central staffs, field offices	A	59	2,183
	SUBTOTAL HCFA	16 (6 central office units and 10 regional offices)		749	$27,713

* Column indicates whether the major purpose of the unit to address fraud (F), abuse (A) and/or waste (W).

HEALTH CARE FINANCING ADMINISTRATION

Medicaid Management Informations (MMIS) produce data and analyses used by state managers to control Medicaid expenditures. These systems also generate data which enable states to identify instances of program abuse. Currently, 36 states, accounting for about three quarters of Medicaid expenditures, have fully certified MMIS. Ten other states are developing systems, and only five states have not started to develop systems.

Medicaid Quality Control (MQC) is a comprehensive management system which complements the states' MMIS. The MQC system reviews a sample of cases to identify errors and incorrect payments and determine the reasons for those errors. MQC findings are used as a basis for corrective action.

Cost Report Evaluation Program (CREP) serves a key component in the assessment of Medicare intermediary performance and HCFA policy in the settlement of hospital and home health agency cost reports. CREP focuses on a review of reimbursement and claims review problems as reflected in a sample of all home health and hospital reports settled by Medicare intermediaries during a fiscal year.

Part B Quality Assurance Program detects payment errors in the Medicare supplemental insurance program. The program focuses on avoidance of future claims processing errors by identifying their sources and making appropriate corrections.

Validation Review Program reviews the appropriateness of claims payment under both Medicare and Medicaid. Audits are focused on areas where there is a potential for misspent funds. Audit results are used as the basis for correction of existing program policies and practices.

Assessments of Medicare Contractor and Medicaid State Agency Performance are used as the basis of evaluating and monitoring contractors' and state agencies' performance in investigating and taking action on suspected cases of fraud and abuse.

Abuse Investigations identify and reduce improper practices by individual health care providers. Two of the most important tools for this identification are Abuse Investigations and Preliminary Fraud Investigations. Both contractors and state agencies are required to investigate situations involving suspected fraud, abuse, or other improper practices. In cases where actual fraud or abuses is detected, the provider is sanctioned through the administrative sanctions program.

Resources Used in Addressing Fraud, Abuse and Waste FY 81

SSA	ACTIVITY	COMPONENT	F/A/W*	STAFF TOTAL	FUNDS ($000)
	OPERATIONS				
	SSI Redeterminations	Field offices, (1350) central operations	W	5140	$135,000
	Continuing disability Investigations	Central operations, (State DDS's)	W	1110	83,000
	Preeffectuation review of disab. determinations	Central operations, field staffs (10)	W	400	10,600
	Fiscal audit and control	Program service centers (6) central operations	F	140	3,500
	SYSTEM SECURITY/ PROGRAM INTEGRITY				
	Program integrity activities	Field integrity staffs, (10) field offices, central integrity staff	F	185	5,200
	Internal security in field offices	Field offices	F	N/A	N/A
	System security officers	All components	F	50	1,500
	SURVEY AND AUDIT				
	Internal surveys and audits	Field staffs (10), central staffs (5)	W	120	3,300
	QUALITY ASSURANCE				
	Quality assurance reviews	Field staffs (10), central staffs (2)	W	2000	59,300
	SUBTOTAL SSA			9145	$301,400

* Column indicates whether the major purpose of the unit is to address fraud (F), abuse (A), and/or waste (W).

SOCIAL SECURITY ADMINISTRATION

SSI Redeterminations are administrative reviews of Supplemental Security Income (SSI) recipients to determine if recipients continue to be eligible for SSI benefits. SSA staff review the total SSI caseload once a year. However, cases with changes in beneficiary status or error-prone cases are reviewed more frequently. This activity is carried out in 1360 SSA field offices and in SSA's central operations.

Continuing Disability Investigations (CDIs) are reviews of persons currently receiving disability insurance (DI) or disability benefits (SSI) to determine if these individuals continue to be disabled. By law, the entire disability insurance and SSI disability caseloads are reviewed every three years. However, additional reviews are targeted on those cases more error-prone and with shorter term disabilities. This activity is carried out by SSA's central operations and the 52 State Disability Determination Service (DDS) Units.

Preeffectuation Reviews are Federal re-reviews of favorable State disability decisions made prior to providing a benefit payment to the disabled beneficiary. These reviews are carried out by SSA's central operations and by 10 field staffs.

Fiscal Audit and Control are reviews of payment transactions to insure program integrity and reconciliation with information provided to Treasury. Reviews are done on a monthly basis through payment tapes. This activity is carried out by six Program Service Centers and SSA's central operations.

Program Integrity Activities are a wide range of detection and investigation activities of beneficiary fraud. This activity is pursued when allegations of fraud are made and when various program tapes are matched and possible fraudulent situations are identified (e.g., an SSI recipient has a bank account but does not report it as a resource). These activities are carried out by 10 field integrity staffs, 1350 field offices, and SSA's central integrity staff.

Internal Security in Field Offices are on-going activities to protect the safety and security of SSA personnel, facilities, and program records. For example, ensuring persons are not able to use the field office telecommunication system to create bogus beneficiary files. These activities are carried out by 1350 field offices.

System Security Officers are those persons responsible, on an on-going basis, for the security of SSA's systems claims processes and offices. Officers are responsible for an active security program (i.e., security planning, audits, risk assessments). All SSA components have such officers (i.e., central operations, field staffs, and field offices).

Internal Surveys and Audits are SSA's internal evaluation activities to determine how well its' components are meeting their goals and the usefulness of current internal procedures (i.e., Quality Control, work flows, accountability controls and processes). These activities are carried out by 10 field staffs and five central staffs.

Quality Assurance are those on-going activities which measure the accuracy of SSA program processes and develop proposals for corrective actions. This activity is carried out by two central office staffs (i.e., Office of Payment Eligibility Quality, and Office of Adjudication) and 10 field staffs.

Resources Used in Addressing Fraud, Abuse and Waste FY 81

PHS

UNIT	F/A/W*	Staff			FUNDS ($000)
		PROFESSIONAL	SUPPORT	TOTAL	
Office of the Assist. Secretary for Health					
- Office of Org. and Mgt. Systems	W	2.5	.5	3	90
- Office of Health Planning & Eval.	W	2	.3	2.3	71
Alcohol, Drug Abuse and Mental Health Administration					
- Office of the Adm.	W	1	.1	1.1	35
Centers for Disease Control					
- Office of the Dir.	W	1.75	1	2.75	72
Food and Drug Administration					
- Office of the Commissioner	W	5	1	6	181
- Bureau of Drugs Div. of Scientific Investigations	F & A	28	7	35	1,030

* Column indicates whether the major purpose of the unit is to address fraud (F), abuse (A), and/or waste (W).

Resources Used in Addressing Fraud, Abuse and Waste FY 81

PHS cont.

UNIT	F/A/W*	Staff			FUNDS ($000)
		PROFESSIONAL	SUPPORT	TOTAL	
National Institutes of Health					
- Office of the Dir.	W	6.5	1.5	8	238
- Office of Admin., Div. of Mgt. Survey and Review	F,A,W	12	2	14	429
Health Resources Administration					
- Office of the Adm.	W	.75	.25	1	28
- Bureau of Health Professions	W	4.75	.25	5	163
- Bureau of Health Facilities	A & W	2	.4	2.4	72
Health Services Administration					
- Office of the Adm.	W	1.5	.5	2	57
SUBTOTAL PHS		67.75	14.8	82.55	2,466

* Column indicates whether the major purpose of the unit to address fraud (F), abuse (A) and/or waste (W).

PUBLIC HEALTH SERVICE

Office of the Assistant Secretary for Health

Office of Organization and Management Systems (OOMS), Division of Management Planning and Quantitative Analysis (DMPQA) and Division of Organization and Management Analysis (DOMA)

DMPQA provides advice and assistance in the design and installation of management planning and control systems for conformance to PHS policies and conducts studies to insure conformance of current systems. DOMA is responsible for establishing and maintaining effective organization structures and functional alignments within PHS. Included in DOMA's responsibilities is conducting management studies which address organizational and management problems of PHS components.

Office of Health Planning and Evaluation (OHPE), Division of Evaluation, Legislation, and Planning (DELP)

DELP conducts evaluations of selected areas of PHS program administration and assesses the techniques of various program evaluations in PHS.

Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA)

Office of the Administrator (OA), Office of Management (OM), Division of Management Policy (DMP), and Division of Grants and Contracts Management (DGCM)

- DMP performs and coordinates studies and surveys on the management of ADAMHA's programs, activities and operations, including those related to personnel utilization, cost, and effectiveness of operations.

- DGCM provides grants and contract administrative and advisory services to the Institutes in ADAMHA. Cost advisory services include examining the financial position and management capability of pre and post-award grantees and contractors when: 1) the grantee or contractor has not previously dealt with the Federal government, or 2) a manager indicates that an awardee or potential awardee experienced significant financial or managerial problems with a previous government contract or grant.

Centers for Disease Control

Office of the Director, Management Analysis and Services Office (MASO)

MASO plans, coordinates and provides CDC-wide administrative, technical, and management services. Included in MASO's activities are studies and surveys of procedures, organizations, functions, and personnel and physical security.

Food and Drug Administration

Office of the Commissioner, Office of Management Operations (OMA), Division of Management Systems and Policy (DMSP) and Division of Contract and Grants Management (DCGM)

- DMSP conducts agency-wide organization and management studies; designs and recommends systems and procedures.
- DCGM provides leadership, direction, and staff advisory services for FDA contracts and grants management programs, including evaluating and reviewing procedures and processes for awarding grants and contracts in FDA Bureaus. DCGM's cost advisory staff examines the financial status of potential grantees and contractors.

Office of the Commissioner, Office of Planning and Evaluation (OPE), Evaluation and Analytical Staff

The Evaluation and Analytical staff advises and assists the Commissioner and other key officials concerning the performance of FDA resource planning, development and evaluation activities. This includes conducting studies that evaluate the effective and efficient management of programs, systems and procedures.

Bureau of Drugs, Division of Scientific Investigations (DSI)

DSI is responsible for implementing FDA's Bio-research Monitoring Programs for Human Drugs. DSI monitors the accuracy of preclinical and clinical drug studies. These activities may include investigations that potentially involve activity by scientific researchers.

National Institutes of Health

Office of the Director (OD), Office for Program Planning and Evaluation (OPPE), Division of Program Analysis (DPA)

DPA conducts and prepares analytic studies and reports to assist the Director of NIH in making broad policy and program decisions affecting the size, scope and direction of NIH programs. DPA's staff members are dispersed throughout the 12 NIH Institutes and have specialized their management reviews in the medical field of their respective Institute.

Office for Administration (OA), Division of Contracts and Grants (DCG) and Division of Management Policy (DMP)

- DCG maintains a continuous review of grant and contract operations in NIH Institutes and Bureaus to insure adherence to Federal, HHS, PHS and NIH Procurement policies and standards. It provides NIH research grants and contracts units with price/cost analysis service and comprehensive advice on the financial position and capability of contractors/grantees that have not previously dealt with the Federal government or have experienced significant financial problems with prior government contracts or grants.
- DMP advises Office of the Director staff and operating officials on management policy, procedures, organization, business, ADP system and related management matters.

Office of Administration, Division of Management Survey and Review (DMSR)

DMSR's responsibilities include investigations of specific problem areas, as requested by NIH top management. The Division operates a program to survey and review the soundness and adequacy of assigned investigative activities, including cases that may include criminal activity (primarily the fraudulent documentation of scientific research results). The Division, during an investigation, verifies factual data. If criminal activity is found, cases are referred to the Inspector General.

Health Resources Administration

Office of the Administrator, Office of Operations and Management (OOM), Division of Grants and Procurement (DGP)

DGP's cost Advisory Staff conducts financial reviews (desk reviews) on contracts awarded for less than $100,000. The purpose of DGP's review is to detect waste and abuse, and possibly fraud. DGP's reviews are conducted after the contractor has spent contract funds. If an expenditure is not in compliance with the terms of the contract, it is disallowed and the contractor has a right to appeal to the Armed Services Contract Board of Appeals.

Office of the Administrator, OOM, Division of Management Policy (DMP)

DMP conducts management studies to determine the efficiency of HRA's operating procedures. These studies result in written reports (e.g., mail usage in HRA, which made recommendations on how to economize in HRA's mailing operations). These studies are designed to improve the efficiency of HRA's operations. DMP also monitors implementation of its recommendations.

Bureau of Health Professions (BHP), Office of Program Development (OPD)

OPD coordinates program planning, reporting, and evaluation activities of BHP divisions and staff offices. Each division (Associated Health Professions, Dentistry, Medicine, Nursing, and Health Professions Analysis) serves as the focal point in its respective area for evaluating program activities. Evaluations focus on program effectiveness (whether the goals of the program are being met in the most cost-effective way).

Bureau of Health Facilities, OPD, Division of Facilities Compliance (DFC)

DFC is responsible for conducting assessments of the operational procedures and records of health facilities to insure that facilities receiving Federal assistance are in compliance with Federal regulations. These assessments are conducted by the Facilities Compliance Staffs in the Regions, and at headquarters. They are in response to a statutory mandate (Title XVI of P.L. 93-641, the Public Health Service Act) and are conducted once every 3 years.

Health Services Administration

Office of the Administrator, Office of Manpower Management

The primary purpose of this office is to assist the Administrator in the effective management of HSA staff resources. The Office of Manpower Management conducts special studies of staff utilization and productivity. These studies identify inefficiencies in resource allocations.

Office of the Administrator Office of Planning, Evaluation, and Legislation (OPEL)

OPEL directs all activities within HSA involving comparing the costs of the agency's programs with their benefits, including the preparation and implementation of comprehensive program evaluation plans. These evaluations assess a program's ability to meet its legislative goals given resources available. Analyses generally address waste in the broadest sense by focusing on programs' operational procedures, with attention on operational inefficiencies.

Resources Used in Addressing Fraud, Abuse and Waste FY 81

HDS

UNIT	F/A/W*	Staff PROFESSIONAL	SUPPORT	TOTAL	FUNDS ($000)
Administration on Aging	W	5	2	7	230
Admin. for Children, Youth and Families	W	2	1	3	85
Admin. for Native Americans	W	3.5	1	4.5	155
Office of Management Services	W	6	1	7	195
OFO - Regions	A & W	52	16	68	2,060
SUBTOTAL HDS		68.5	21	89.5	2,725

* Column indicates whether the major purpose of the unit to address fraud (F), abuse (A) and/or waste (W).

HUMAN DEVELOPMENT SERVICES

Administration on Aging

Office of Research, Demonstration and Evaluation,
Division of Research and Evaluation

The Division of Research and Evaluation, among other functions, administers the program of research authorized under Title IV-B of the Older Americans Act, including monitoring progress and evaluating the performance of grantees and contractors. This division also administers evaluations of AOA programs and other related national programs.

Administration for Children, Youth and Families

Office of Developmental Services, Youth Development Bureau (YDB)

The Youth Development Bureau plans, develops, and implements an integrated program of research, demonstration, and evaluation to investigate and assess a broad range of programs delivering services to youth. A major purpose of YDB's evaluations is to determine the effectiveness of the projects funded under Title III of the Juvenile Justice and Delinquency Prevention Act of 1974 in achieving legislative goals.

Administration for Native Americans

Office of Planning and Program Development, Division of Research, Demonstration and Evaluation (DRDE)

DRDE, among other functions, conducts intra-agency evaluations and studies on program effectiveness; and assists the evaluation efforts of other agencies relevant to Native American populations. Examples of reports completed by the division are: "Assessment of the Overall Impact of ANA Programs on the Planning and Management Systems and Practices of Reservation Grantees," (1978); and "A Study and Analysis of the Role of the Administration for Native Americans in Twelve Native American Communities" (1978).

Office of Management Services (OMS)

OMS plans, organizes, and conducts surveys and management reviews of administrative processes and functions in HDS program and staff components (e.g., processes all discretionary grant award documents). This staff also serves as HDS' liaison with GAO, HHS Audit Agency, and the Department's Office of Grants and Procurement on all grant and contractural matters. OMS also evaluates ADP systems. The following are examples of HDS information systems which OMS will evaluate in FY 82: Administration on Aging Clearinghouse Information System; HDS Contracts Tracking System; and ACYF Runaway Youth.

HDS Regional Offices

Offices of Fiscal Operations (OFOs)

These offices conduct financial reviews of State expenditure reports to determine whether these expenditures were made in accordance with the grant plans. If expenditures are not in accordance with grant plans, the Regional OFOs will recommend disallowances.

Resources Used in Addressing Fraud, Abuse and Waste FY 81

OS

UNIT	F/A/W*	Staff			FUNDS ($000)
		PROFESSIONAL	SUPPORT	TOTAL	
Assistant Sec. for Personnel Admin. - Div. of Per. Systems Improvement	A	2	.5	2.5	90
Assistant Sec. for Planning & Evaluation (Evaluation Function) - ASPE	W	12.2	NA	12.2	488
Assistant Sec. for Mgt. and Budget - OMAS/Office of Computer Info. Systems	W	4	.75	4.75	175
Assistant Sec. for Mgt. and Budget - OMAS/Office of Mgt. Analysis	W	10	3.75	13.75	470
Assistant Sec. for Mgt. and Budget - Office of Procurement Assistance & Logistics (OPAL)	W	8.4	1.5	9.9	366
Assistant Sec. for Mgt. and Budget - OPAL/Division of ADP Review	A	4	.75	4.75	175
Office of Civil Rights - Office of Quality Assurance	W	1.5	.5	2	70
SUBTOTAL OS		42.1	7.5	49.6	1,834

* Column indicates whether the major purpose of the unit to address fraud (F), abuse (A) and/or waste (W).

OFFICE OF THE SECRETARY

Assistant Secretary for Personnel Administration (ASPER)

Division of Personnel Systems Improvement (DPSI)

DPSI conducts special studies relating to the effectiveness of personnel management programs. DPSI reviews identify deficiencies, analyze causes and recommends corrective actions on problems related to the Department's personnel system.

Assistant Secretary for Planning and Evaluation (ASPE) - Evaluation Function

The evaluation function of the ASPE focuses on detecting waste by examining programs to determine if they are effective and are fully meeting their expectations. Evaluation studies ASPE has recently initiated are geared toward achieving program cost savings and increased efficiencies.

Assistant Secretary for Management and Budget (ASMB)

Office of Management Analysis (OMA)

OMA conducts management studies and also provides independent management consulting services to the Department. These studies determine how effectively managers are operating their programs/activities and recommend ways to improve effectiveness. OMA's studies and reviews are generally directed toward avoiding waste by identifying and correcting inefficient uses of resources. OMA reviews proposed contracts for non-evaluation consulting services and eliminates waste by disapproving contracts that do not meet the objectives of a program or involve activities which should be done using in-house resources.

Office of Computer and Information Systems (OCIS)

OCIS is primarily responsible for evaluating information systems throughout the Department. The studies and reviews conducted by OCIS are to insure that: (1) uniformity is maintained in Departmental information systems; (2) systems acquisitions are not unnecessarily duplicative (OCIS reviews all system acquisition requests over $150,000); and (3) the ADP systems are properly secured to avoid improper use. OCIS provides proposed corrective actions for eliminating wasteful practices it identifies during its reviews.

STATEMENT OF ROBERT SERMIER, DEPUTY ASSISTANT SECRETARY FOR MANAGEMENT ANALYSIS AND SYSTEMS, HHS

Mr. **Sermier**. I am Robert Sermier and I have management oversight for the Department's general efforts to combat fraud, abuse and waste.

In your letter of invitation, you asked three questions specifically of our Office. I will just highlight the answers which I think are most appropriate in view of the tenor of this morning's testimony.

First of all, there are approximately 10,000 people outside the Office of the Inspector General primarily in the Health Care Financing Administration and Social Security Administration who are devoted virtually fulltime to identifying fraud, abuse and primarily wasteful activities. These people are in 42 units outside of SSA and in numerous units within the Social Security Administration. The total cost of supporting those people was $336 million in fiscal year 1981.

What they do is very much integral to what we all do at the Department. And, in fact, the 10,000 people greatly understates the number who work in one way or another on fraud, abuse, and waste prevention efforts in the Department. In a very real sense, almost everyone at some time during the day and most of us during the day are concerned with some aspects of preventing fraud, abuse and waste.

I want to stress that the Secretary of the Department has several initiatives underway. I will highlight only one: The savings program. That is a formal program dedicated to documenting the savings we achieve from our efforts to reduce wasteful expenditures and prevent fraud and abuse. The results from that program were that we documented $1.4 billion in savings in fiscal year 1979. That included the components which are now in the Department of Education. They contributed $400 million so that the components in the Department of Health and Human Services saved $1 billion, a documented $1 billion, in fiscal year 1979. In fiscal year 1980, those components saved $1.4 billion.

I only have partial returns for fiscal year 1981 even though that year has ended because there are data lags in our systems. One of the key features of the system is that we do not estimate recoveries, we document the recoveries. Thus, we do not record results until they have actually taken place. Until we can, to our satisfaction, demonstrate that there have been changes in error rates or that we have actually collected money, we do not document savings until something in the real world occurs which we can then translate into dollar savings.

Now, some of the efforts that are included under the savings program are efforts to improve the productivity of medicare contractors, reduce error rates in all our major payment systems programs, and increase child support enforcement collections.

Secretary Schweiker has not only reinforced this program, he has added several improvements. There are several systems improvements plus major emphases on new efforts to collect our debts and to improve our cash management techniques.

At his specific direction, we have installed truly systematic processes to follow up on audit reports by the Inspector General and by the General Accounting Office.

Previously, we were following up in a fairly systematic way on monetary findings associated with those reports. Now, at the Secretary's insistence since last March, we are following up on a nonmonetary finding with essentially the same degree of rigor.

That concludes my testimony, Mr. Chairman. And I will be ready to answer questions with my colleagues.

[Answers to questions from Senator Dole.]

Question 1. It is clear from your testimony that there is considerable reliance on Medicare contractors and Medicaid State agencies in identifying, investigating, and taking action on suspected cases of fraud and abuse. However, OMB is insisting on a reduction of $115 million in Medicare contractor operations from a House and Senate approved appropriation of $725 million. What effect is this likely to have on the ability of contractors to carry out the current level of audit and to sustain fraud and abuse identification activities?

Answer. The FY 82 budget for Medicare contractors was reduced to $691 million. In order to maintain the basic claims processing function (e.g., paying claims and maintaining eligibility, deductible and utilization records) within this funding level, there has been a reduction in funds available to the contractors for audit and reimbursement activities. The $49.6 million to be spent by the contractors on these activities this year is 21 percent less than the FY 81 level. To maximize the return on these dollars, the contractors will use the funds budgeted for audit to target their work in the areas in which the greatest payback can be expected.

Question 2. Under HCFA instructions, carriers are not allowed to attempt to recover overpayments on cases where an IG fraud investigation is in process. The carriers have complained that the opportunity to recover these amounts is often lost.

Have you made any attempt to resolve this problem? If so, have recoveries increased?

Answer. These instructions are not unique to HCFA. They are designed to prevent any action taken by the carrier from inadvertently prejudicing the fraud investigation. Such instructions are common in administrative agencies and stem from directions by the Department of Justice to defer and delay administrative action in cases involving fraud investigation. Delays in administrative collection action pending completion of fraud investigations leading to lost collections have not been a problem in the Medicare program. The Medicare overpayment recovery reporting system contains an early warning mechanism designed to prevent such loss. It flags each overpayment case in which the federal statute of limitations (generally six years from the date of determination of overpayment) is due to expire in less than two years. These cases are given special handling so that the coordination and action necessary to bring the case to conclusion administratively or to the federal courts for collection within the six year period is accomplished.

At present two projects are underway within HCFA which will further improve this system. First, the Bureau of Program Operations (BPO) and the Bureau of Quality Control (BQC) are working to integrate their respective reporting systems to assure that all overpayment activity (including fraud and abuse) is timely reported and accurately monitored from determination to resolution. Secondly, during FY 1982, all instructional materials are being reviewed to identify areas in which they can be modified to reduce costs/burdens. Because prompt and complete recovery of overpayments reduces program costs, HCFA is carefully reviewing instructions regarding cases in which fraud investigation are involved to assure that such investigations do not lead to lost opportunities to recover overpayments. Even when fraud investigations are involved in a given case, many administrative actions can be undertaken, with knowledge and consent of the Inspector General or Department of Justice, to recover overpayments and HCFA wants to assure that, where appropriate, such actions are promptly taken.

Question 3. It was as early as September 1974 that Dr. Kones was convicted of a Medicare fraud scheme.

Does HCFA have a system to identify high risk providers such as Dr. Kones to Medicare contractors and Medicaid agencies whether or not the provider is sanctioned?

Answer. The Health Care Financing Administration has recognized for some time that an effective effort to detect and control fraud and abuse in the Medicare and

Medicaid program requires that there be an open exchange of pertinent information between HCFA and its contractors and the State agencies responsible for administering these programs. The Health Care Financing Administration is also responsible for ensuring that beneficiaries' privacy is maintained, and that unwarranted disclosures of Medicare information are prevented. The following is a description of the mechanisms which HCFA has in place to ensure the efficient exchange of fraud and abuse related information.

A. AGREEMENTS FOR THE EXCHANGE OF INFORMATION BETWEEN MEDICARE CONCENTRATORS AND MEDICAID STATE AGENCIES

In 1980 HCFA issued Program Integrity Regional Letter 79-32 entitled "Exchange of Title XVIII and Title XIX—Information" (attachment A), which clarified the authorities applicable to the Medicare/Medicaid Information exchange and to provide the HCFA regional offices with the basic framework within which to conduct the exchange of information. Since this regional letter was issued, HCFA has initiated and directed discussions between Medicare contractors and Medicaid State agencies and Fraud Control Units in their areas aimed at establishing acceptable information exchange agreements. These agreements contain the following essential elements: (1) a clear delineation of the respective responsibilities of HCFA, the Medicare contractor(s), and the State agency or Fraud Control Unit; (2) a discussion of the specific categories of data which may be directly exchanged without obtaining HCFA/BQC concurrences for each exchange; (3) a discussion of the data exchange procedures to be followed, including necessary recordkeeping; and (4) an overall statement of the objectives of the information exchange agreement.

These agreements will substantially improve the exchange of fraud and abuse information between Medicare contractors and Medicaid State agencies.

B. EXCHANGE OF ADMINISTRATION SANCTION INFORMATION

Section 1128 of the Social Security Act provides that whenever an individual is convicted of a Medicare/Medicaid or Social Services program violation, the Secretary must suspend the individual from Medicare program participation for a period which the Secretary determines is appropriate. The appropriate State Medicaid agency is required to suspend the convicted individual from the Medicaid program for the same period as the Medicaid suspension. The Secretary also imposes Medicaid exclusion on providers, physicians, and suppliers of services who have defrauded or abused the Medicare program. The Health Care Financing Administration informs all State agencies and Medicare contractors of these sanctions on a monthly basis. Conversely, State agencies are required to report to the Secretary on all administrative sanctions which they impose under provisions of section 1902(a)(41). Through these systems, there is a continuous exchange of all administrative sanctions related information.

C. THE HEALTH CARE FINANCING ADMINISTRATION'S WORKLOAD REPORTING SYSTEM

In July 1981 HCFA implemented a computer based system for tracking cases of suspected abuse. Data on providers, practitioners, and suppliers who are suspected of abusing the Medicare program are entered into the system at each of the ten HCFA regional offices and this information is periodically transmitted to the HCFA central office where a national file is maintained. This national file already contains over 20,000 case records.

Each of the case records contains information including the name of the subject, the nature and source of the abuse complaint, and the final disposition of the case including any overpayment assessed or sanction action taken. The system is designed to permit the retrieval of an entire case record either from the regional office or central office in a matter of minutes.

The system enables the HCFA regional office to effectively coordinate investigative activities between the Medicare and Medicaid programs. In addition to the quick retrieval of case records, the system will be used to identify situations in which concurrent Medicare and Medicaid investigations are underway in order to assure maximum coordination. The Health Care Financing Administration will also share its Medicare investigative information with States as leads for their Medicaid investigations.

The system also has a national search capability which will be used to respond to congressional and media inquiries.

The Health Care Financing Administration is continually working to improve its system for the exchange of fraud and abuse information with other affected entities.

Agreements are now being negotiated with the Department of Defense in order to strengthen the CHAMPUS program integrity efforts. In addition, we are attempting to improve our exchange of information with the Office of the Inspector General which has the responsibility for Medicare fraud investigations.

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

REGIONAL LETTER

Subject: Exchange of Title XVIII and Title XIX Information.

Based on a number of inquiries from and discussions with regional and central office staff, there appears to be some continuing confusion and misunderstanding regarding the types of information that can be exchanged between title XIX agencies (State agency, fiscal agent, fraud control unit) and title XVIII entities (HCFA and fiscal contractors). In an attempt to resolve much of this confusion and misunderstanding, we have prepared the following, rather lengthy, discussion on the current authorities to exchange information. While no discussion of this type can be all-inclusive, we have attempted to provide the basic framework within which a coordination/exchange effort can take place.

Disclosure of Title XVIII Information to Title XIX Agencies

The regulations at 20 CFR 401.3 provide the basic guidelines for the disclosure of title XVIII information to title XIX agencies. Pursuant to these regulations, HCFA is authorized to release to title XIX agencies (i.e., the State Medicaid agency and the fiscal agent, and the State Fraud Control Unit) any information whose release is not prohibited by the Privacy Act (or any other statute). Supplementing these general guidelines, regulations at 20 CFR 422.434 more specifically detail the types of information disclosable by HCFA. As amended by the March 17, 1977 interim regulation at 20 CFR 401.3, this section provides the following guidelines for the disclosure of title XVIII information to a State Medicaid agency, fiscal agent, and State Medicaid Fraud Control Unit.

Payment and Certification Data. The following types of information may be disclosed to a State Medicaid agency, fiscal agent, or State Medicaid Fraud Control Unit:

(1) Information, including the identification number, concerning charges by physicians, other practitioners, or suppliers, and amounts paid under title XVIII of the Act for services furnished to beneficiaries by these physicians, practitioners, or suppliers to enable the agency to determine the proper amount of benefits payable for medical services performed in accordance with the title XIX program.

(2) Information relating to the qualifications and certification status of hospitals and other health care facilities obtained in the process of determining and certifying as to whether institutions or agencies meet or continue to meet the conditions of participation for their respective facilities or continue to meet the conditions for coverage of services they furnish. Such information about a hospital, skilled nursing facility, or home health agency, as well as such information about independent laboratories, providers of outpatient physical therapy, and portable X-ray supplies may be disclosed to a State agency when disclosure is necessary for the proper administration of the State plan.

Fraud and Abuse Information. The following types of information may be disclosed to the enforcement branch of a State Medicaid agency or to a State Medicaid Fraud Control Unit, *provided*, that such agency or unit has in effect a signed, written agreement with the Secretary, whereby the agency agrees to preserve the confidentiality of the information it receives from HCFA, and further agrees to use such information solely for the efficient and effective administration of the Medicaid program:

(1) The name and address of any provider of medical services, organization, or person being actively investigated for possible fraud in connection with title XVIII, as well as the nature of the suspected fraud. By the "nature" of the suspected fraud, we mean all case file records, payment records, beneficiary and witness statements, and other pertinent documentation relating to our supporting the allegation of fraud. In accordance with the Program Integrity case files system notice described below, HCFA may disclose this information to the State agency or fraud control unit to assist in their investigation of situations involving possible fraud in the Medicaid program.

(2) The name and address of any provider of medical services, organization, or other person found, after consultation with an appropriate professional association, to have provided unnecessary services, or of any physician or other individual found to have violated the assignment agreement on at least three occasions. Disclosure of

such information is designed to ensure that the State agency is aware of potential abuses in the title XIX program, based on abuses committed in connection with the title XVIII program. The requirement that an appropriate professional association (e.g., a PSRO, in-house medical consultants, or other review bodies) be consulted prior to disclosure, has been established to ensure that a medical determination regarding the necessity of services be obtained from qualified individuals; this medical determination, in turn, should form the basis for HCFA's decision to release or withhold information.

(3) The name and address of any provider of medical services, organization, or other person that was previously released under (1) or (2) concerning when an active investigation is concluded with a finding that there is no fraud or other prosecutable offense.

In addition to the guidelines provided in the regulations at 20 CFR 422.434, the authority to disclose information is also described in the notices of the systems of records published in the Federal Register for the Program Integrity case files, and the Medicare carrier and intermediary claims records. (Note: These systems notices are published in the Federal Register at least annually, as a requirement of the Privacy Act to publish a notice of the existence and character of each system of records maintained by an agency and the routine uses which may be made of the records in the system.)

The Medicare carrier and intermediary claims records system notices (published October 9, 1979, in Volume 44 of the Federal Register, pp. 58240-43) identify as a routine use of certain categories of the records maintained by the carriers/intermediaries for HCFA—including billing and payment records—the following:

"(1) State welfare departments pursuant to agreements with the Department of Health, Education, and Welfare for administration of State supplementation payments for determinations of eligibility for Medicaid, for enrollment of welfare recipients for medical insurance under section 1843 of the Social Security Act, for quality control studies, for determining eligibility of recipients of assistance under titles IV and XIX of the Social Security Act, and for the complete administration of the Medicaid program."

Similarly, the Program Integrity case files systems notice (at 44 FR 58258-59) includes as a routine use of the fraud and abuse case files maintained by the Office of Program Integrity the following:

"HCFA discloses such information to officers and employees of State governments as well as the civilian health and medical program of the Uniformed Services (CHAMPUS) program for use in conducting or directing investigations of possible fraud or abuse against the title XIX or CHAMPUS programs, as well as State attorneys in connection with State programs involving the Health Care Financing Administration."

Disclosure of Title XIX Information to Title XVIII Agencies

The regulations governing disclosure of title XIX information to title XVIII agencies (HCFA and its fiscal contractors) reflect the concomitant concerns of preserving the confidentiality of a person's records, while also ensuring the efficient administration of the title XIX program. The following regulatory and statutory provisions impact on this disclosure:

Section 1902(a)(7) of the Act and implementing regulations at 42 CFR Subpart F, require a State plan to provide safeguards that restrict the use or disclousre of information concerning applicants and recipients to purposes directly connected with the administration of the plan. Specifically, 42 CFR 431.302 states that purposes directly related to plan administration include (a) establishing eligibility, (b) determining the amount of medical assistance, (c) providing services for recipients, and (d) conducting or assisting an investigation prosecution, or civil or criminal proceeding related to the administration of the plan.

Section 1902(a)(6) of the Act and implementing regulations at 42 CFR 431.16 require the State agency to submit such reports in such form and containing such information as the Secretary may require, and to comply with any provisions that the Secretary finds necessary to verify and assure the correctness of the reports.

Regulations at 42 CFR 455.17 further require each State agency to report the following information to HCFA:

(A) The number of fraud and abuse complaints made to the State agency that warrant a preliminary investigation;

(B) For each case of suspected fraud and abuse that warrants a full investigation—

(1) the provider's name and number,
(2) the source of the complaint,

(3) the type of provider,
(4) the nature of the complaint,
(5) the approximate range of dollars involved, and
(6) the legal and administration disposition of the case; and

(C) A summary of the data reported under (A) and (B) above.

Similar to the reporting requirements above for State agencies, regulations at 42 CFR 455.300(f)(5) require each State fraud control unit to "make available to Federal investigators or prosecutors all information in its possession concerning fraud in the provision or administration of medical assistance under the State plan and shall cooperate with such officials in coordinating any Federal and State investigations or prosecutions involving the same suspects or allegations."

Additionally, State fraud control unit regulations at 42 CFR 455.300(i)(2) require that—

> The unit shall also provide any additional reports that the Secretary requests, and shall comply with any measures the Secretary deems necessary to assure the accuracy and completeness of all reports required under this paragraph (i).

Finally, as grantees or subgrantees of HEW grants, title XIX agencies are subject to the regulatory provisions governing grant administration (Part 74 of 45 CFR). Specifically, 45 CFR 74.23(a) requires that the Secretary, or his duly authorized representative, shall be granted access to information in the possession of these entities:

> HEW and the Comptroller General of the United States, or any of their duly authorized representatives, shall have access to any books, documents, papers, and records of the grantee which any of them determine are pertinent to a specific HEW grant, for the purpose of making audit, examination, excerpts, and transcripts.

Part of the confusion on this issue of disclosure of title XIX information arises from the apparent conflict between the requirements that (1) disclosure and use of recipient/applicant information be restricted to purposes directly related to State plan administration and (a) information be disclosed to the Secretary (i.e., HEW or HCFA) as required by the Secretary. While we believe that the restrictions imposed by 42 CFR 431.302 do not apply to disclosures to HEW or HCFA, the argument can nevertheless be made that even if these restrictions did apply, title XIX State agencies would still be in compliance with the regulations if they were to disclose recipient/applicant information to HEW or HCFA in response to requests which are for the purposes of (a) establishing or verifying the eligibility persons for medical assistance, (b) determining the amount of medical assistance and ensuring that such amount is proper, (c) providing services to recipients (this would include ensuring that services are provided in a manner consistent with the best interestrs of recipients and with simplicity of administration, and safegurding against unnecessary utilization of such care and services), and (d) conducting or assisting an investigation (initial or full-scale), prosecution, or civil or criminal proceeding related to the title XIX program.

Discussion

An effective effort to detect and control fraud and abuse in the Medicare and Medicaid programs requires that there be an open exchange of needed information between Federal and State agencies responsible for administering these programs, while concomitantly ensuring that unwarranted disclosures of information are prevented. We are, therefore, concerned that there may be some confusion regarding what information can be disclosed and by whom. The discussion above outlines the regulations and statutory provisions which govern this exchange of information. However, there have been some questions relative to the application of these regulatons/statutes.

For example, since much of the information on suspected instances of title XVIII abuse[1] results from activities of the carrier/intermediary (such as postutilization and postpayment review audits, etc.), questions have been raised regarding the feasibility/legality of contractors (carriers and intermediaries) exchanging information with title XIX agencies or fiscal agents for the purpose of detecting potential abusive or fraudulent situations. The regulations at 20 CFR 422.434 explicity state that the "release of such information shall not be authorized by a fiscal intermediary or carrier;" i.e., prior HCFA authorization must be obtained before such disclosure may be made.

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[1] By abuse we mean those practices which are inconsistent with sound fiscal, business, or medical practices and which result in an unncessary cost to the Medicare program or which result in program reimbursement for services which are not medically necessary or are of a quality which fails to meet professionally recognized standards of care. This would include unnecessary services, improper billing practices, and assignment agreement violations.

This does not mean that HCFA must authorize each specific disclosure of information to a title XIX agency. However, it does require that the carrier or intermediary obtain HCFA approval for the categories of information disclosed, and the systems or mechanisms established for disclosing the information. In addition, HCFA should maintain an ongoing monitoring activity of these systems and the information disclosed, to ensure that improper disclosures are not being made.

As a case in point: a contractor functions as both the carrier for title XVIII and the fiscal agent for title XIX. To maintain an effective fraud and abuse detection effort, the contractor proposes establishing a combined title XVIII—title XIX postpayment review system. This will necessitate a sharing of title XVIII and title XIX information, and close coordination between carrier/fiscal agent/State agency personnel. To ensure that the proposed system will not result in any improper disclosures of title XVIII information to State agency/fiscal agency personnel, HCFA must review and approve this system prior to its implementation. If HCFA does approve the system, it should maintain an ongoing monitoring activity of the types of title XVIII information disclosed, and the uses made of such information.

The importance of this approval/monitoring function should not be minimized. Any agency employee or officer who discloses information whose disclosure is prohibited, is subject to a fine of $5,000. Because of the criminal penalty for improper disclosure of information, it is imperative that each HCFA regional office ensure that systems implemented by carriers/intermediaries to coordinate title XVIII—title XIX information exchange, will result only in the authorized disclosure of title XVIII information. Further, HCFA must take adequate measures to ensure that title XVIII information which is disclosed will be used only for the proper administration of the title XIX program, and will not be redisclosed improperly and, similarly, that title XIX information is not improperly disclosed or used.

A second question raised has been whether title XIX agencies are required to disclose information to HCFA. The statute (at Section 1902(a)(6) of the Act) and regulations discussed in this paper are clear in requiring title XIX agencies to comply with requests by HCFA and HEW for information. Regardless of whether such requests concern nonapplicant/nonrecipient data (statistical reports, fraud and abuse reports and forms, etc.) or recipent/applicant information, title XIX agencies must comply with the requests.

Because of the multitude of regulations and statutory provisions impacting on this exchange, the issues and situations involved are often complex, requiring careful application of these regulatory/statutory provisions. We hope, however, that this analysis and discussion of the regulations/statutes governing the exchange of information between title XVIII and title XIX agencies is helpful in providing guidance and assistance in the development of an effective exchange.

Should there be additional questions on this material discussed above, please contact Bill Broglie on (FTS) 934-8829.

LEONARD D. SCHAEFFER,
Administrator.

STATEMENT OF MARTIN KAPPERT, DEPUTY ASSOCIATE ADMINISTRATOR FOR PROGRAM OPERATIONS, HEALTH CARE FINANCING ADMINISTRATION

Mr. KAPPERT. I am Martin Kappert and I am very pleased to be with you to discuss HCFA efforts to combat fraud, waste and abuse in the medicaid and medicare programs.

Our program, as you well know, provides health insurance coverage for more than 50 million people, or about 22 percent of the total population.

Most notably, as others have stated already today, last year our expenditures reached almost $60 billion. Thus, the goal of assuring the integrity of health care financing programs is as fundamental a concern to us as it is to you.

We intend to be sure that program payments are provided only to eligible beneficiaries for appropriate services at a reasonable rate. We attack this problem at three levels. We must, in the first instance, have in place fundamental controls as an integral part of our everyday operations. As an example of magnitude, our medicare contractors next year will be responsible for more than 235 million processing transactions; that is claims and bills.

Second, we recognize the major responsibility to identify and redress improper practices by individual health care providers.

Finally, in exercising the first two responsibilities as well as our overall responsibility for administration of the program, we constantly reexamine the programs for areas of vulnerability to abuse and for improvement opportunities. This is particularly true with respect to conserving program dollars.

Now, in the interest of time, I did not intend—although it's a matter of record—to describe all the individual systems we have. But I think after this morning's testimony it is important to state that there are systems in place, routine systems, that examine the kind of things and prevent the kinds of instances that were described so graphically this morning.

Most of the people that we have in HCFA who deal with this particular family of problems are either in our Bureaus of Quality Control and Program Operations or in our regional offices. All of these, with the recent realinement of HCFA, fall under the same associate administrator.

Given the complexities of our programs and the magnitude of our expenditures, we welcome the contributions the Inspector General has made to curbing fraud, abuse, and waste in our programs, including the direct pursuit of medicare fraud cases discussed this morning, support of the medicaid fraud control units which we also heard about this morning, and, finally, the audit recommendations cited in other testimony and the request for our response.

We have taken the Inspector General's recommendations quite seriously. And we have taken a number of actions in specific response to them. In addition to the financial recoveries, and so forth, already alluded to, we are initiating reviews of various policies and procedures, revising regulations, and we continue to work with the IG to find new initiatives and new auditing approaches.

Further information regarding all these areas, as I indicated, is attached to my formal statement. And I will be very happy to answer any questions.

[Answers to questions by Senator Heinz.]

Martin Kappert, Deputy Associate Administrator
Program Operations, HCFA

Questions for the Hearing Record
December 9, 1981

1. In preparation for your appearance before the Committees on December 9, 1981, you were asked to track specific recommendations for program change suggested by HHS IG in 1980. What program change has resulted from the recommendations of the Inspector General in 1980? Please indicate in your response the date these changes were suggested, the date of implementation, and the date and manner of notification of the IG that these program changes were in progress. Please also detail the changes that were not implemented and the reasons they were not implemented.

2. What other changes in program operation have resulted from the IG's recommendations to this date? Please identify by program, date of suggestion (month and year), date of implementation and change.

3. Program validation activities are similarly targeted at effecting program change. What changes, if any, in the way programs operate resulted from Program validation activities?

4. Does any one in the Bureau of Quality Control coordinate and compare the recommendations of Program Validation, those of the IG, other Departmental recommendations (please specify the Department), and external recommendations? If so, where are these people located within the Bureau? How many people are engaged in this activity?

5. Once an OI investigation is terminated by the Justices declination and returned to BQC, what is the Bureau's process for tracking the case and assuring other appropriate remedies are considered? What mechanism is employed? Is there a central control point? Who has this responsibility?

6. You were asked to come prepared to specify the administrative and civil sanctions that followed OI action in the forty-one health cases presented for prosecution in 1980. What action has been taken on these cases? Please identify by case number and indicate action taken and date.

QUESTION #1. In preparation for your appearance before the Committees on December 9, 1981, you were asked to track specific recommendations for program change suggested by HHS IG in 1980. What program change has resulted from the recommendations of the Inspector General in 1980? Please indicate in your response the date these changes were suggested, the date of implementation, and the date and manner of notification of the IG that these program changes were in progress. Please also detail the changes that were not implemented and the reasons they were not implemented.

ITEM 1. 15-00200 - Management of Personal Care Services (PCS) Authorized under title XIX - June 13, 1980.

ANSWER. We agree that the regulations defining personal care services at 42 CFR 440.170(f) needed revision. However, due to the priority handling of the provisions of the Omnibus Reconciliation Act of 1980 (P.L. 96-499) and the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) the personal care services regulation revision could not proceed as quickly as we had planned.

The Inspector General is correct in pointing out that personal care services is one of the services that may be furnished by waiver under the home or community-based services provisions under section 2176 of P.L. 97-35 and as defined in regulations at 42 CFR 440.180. We have, for the present, also allowed States to furnish personal care services as defined at 42 CFR 440.170(f) without obtaining a waiver under the other medical or remedial care provisions of 42 CFR 440.170. However, as part of the Government-wide regulatory reform effort, we are actively reviewing all current Medicaid regulations including 42 CFR 440.170(f) and will determine whether this regulation should be deleted or if it needs to be revised to more specifically define the nature and scope of covered personal care services. We hope to complete our review of this provision of the Medicaid regulations early this calendar year.

In the Inspector General's note to Carolyne Davis dated November 20, 1981, it was pointed out that in the OIG's 1980 Annual Report, one State was identified as charging housekeeping services (at a rate of $1 million per month) to Medicaid without linking these services to a physician's plan of medical treatment.

We wish to clarify that the State in question was not providing personal care services without a link to a physician's plan of treatment. As previously indicated in correspondence to the OIG on October 14, 1980, and based on the Office of the General Counsel's opinion that the services referred to in the subject memorandum followed current regulations including being prescribed by a physician, we concluded that the disallowance recommended by the audit agency could not be sustained in the courts. The Office of the Inspector General Audit Agency's legal counsel also concluded that the disallowance would not be appropriate. Regulations at 42 CFR 440.170(f) clearly state that the services must be prescribed by a physician in accordance with the recipient's plan of treatment and, contrary to the statements made in correspondence we received from the Inspector General, the services in question were so prescribed.

ITEM 2. 06-02001 - Report on Need for More Restrictive Policy and Procedures Covering Medicare Reimbursement for Medical Services by Hospital-Based Physicians - August, 1980.

ANSWER. HCFA published a notice in the Federal Register on March 11, 1980, which advised the public that effective with services furnished after June 30, 1980, the provisions of 42 CFR 405.482(a) and 42 CFR 405.483 (a) will be uniformly enforced by Medicare carriers and intermediaries. This action generally precludes reasonable charge reimbursement for clinical laboratory services furnished to entitled Medicare patients in hospitals and skilled nursing facilities. Prior program reimbursement of reasonable charges for these services has contributed significantly to the levels of hospital-based pathologists' compensation previously reported to the Inspector General. However, implementation of that notice to enforce the regulation has been delayed by the U.S. District Court pending the outcome of a lawsuit challenging HCFA's intended enforcement action.

Following a lawsuit which challenged the legal effect of the March 11, 1980, Notice, HCFA was preliminarily enjoined from implementing its intent.

On October 6, 1981, HCFA published a Notice in the Federal Register withdrawing the earlier Notice in order to reassess the policy it represented and to develop any appropriate changes in the rules governing reimbursement for the services of hospital-based physicians.

Since October, HCFA has reviewed its regulations governing reimbursement for these services and has met with members of professional organizations that represent hospitals and hospital-based physicians to consider changes that have occurred since 1966 in the delivery of health services by these physicians. Following assessment of the information received during these meetings, HCFA has developed recommended modifications to the existing regulations that will be presented to the Secretary of HHS early this calendar yearfor approval. Once approved by the Secretary these modifications will serve as the basis for an NPRM. In considering these changes, we have endeavored to be as creative and responsive as possible to the issues raised in the Inspector General's report within the framework of present law. If we identify potential approaches that cannot be achieved under current law during the deliberative process now underway, we will request assistance in developing appropriate new legislative directions.

While it is difficult to predict the length of time a full consideration of the modifications will entail, we hope to publish the intended changes in the Federal Register early in 1982 for comment. Full implementation of these regulatory changes will address the issues raised in the subject report.

ITEM 3. 04-03001 - Report on Review of the Implementation of the Requirements for Teaching Physicians to Qualify for Reimbursement Under Medicare and Medicaid - November 3, 1980.

ANSWER. HCFA did not concur with the recommendation to require teaching physicians to define and quantify the services by specifying whether the claim is for services as the patient's attending physician or for personal and identifiable medical services actually rendered to the patient because 42 CFR 405.521(b) provides that attending physician services that meet program guidelines are of the same character as personally furnished services. Accordingly, once an attending physician relationship is documented in the chart, we consider personally supervised services to have the same status as those personally furnished. Paragraph (c) indicates that reasonable charges for attending physician services are determined in accordance with the generally applicable reasonable charges. We know of no instance in which reasonable charges have been reduced solely because attending physician services rather than personally furnished services were involved. The level of program payment is the same. As such, requiring the distinction to be documented in billing would be burdensome and most importantly, offer no program improvement.

HCFA concurred, within the framework discussed below, with the recommendation to require teaching physicians to certify to the extent of their involvement in the services with a certification statement similar to the one currently required in machine billing. 42 CFR 405.521 authorizes reasonable charge payments for attending physician services in a teaching setting. However, there must be some "teaching effort" going on in a "teaching setting." If the physician involvement is strictly a teaching one as explained in Intermediary Letter (I.L.) 372 (A) (4), then no attending physician relationship exists, and no charges are payable.

The fact that some "teaching effort" is involved does not rule out reasonable charge payment for the physician. It is the extent of personal physician involvement rather than "teaching effort" that is the key to reasonable charge payment.

We agree that it could be desirable to require teaching physicians to certify to the extent of their involvement in the services with a certification statement similar to the one currently required in machine readable format billing and are examining whether this is practical.

Section 948 of Public Law 96-499, the Omnibus Reconciliation Act of 1980 incorporated into the statute the basic program policies contained in I.L. 372 and introduced a new method for determining the customary charges for physician services in a teaching setting. HCFA continues to believe that uniform implementation of section 948 will resolve the issues raised in the Inspector General's report.

We are developing regulations to implement this amendment. We expect that publication of the proposed rule will occur in early spring 1982 and that the final regulation will be published later in 1982.

ITEM 4. Service Delivery Assessment Recommendations provided to the Secretary in 1980 - Medicare Part B Beneficiary Services - August, 1980.

ANSWER. With regard to the recommendation to upgrade the outreach programs for beneficiaries, HCFA has established, as a focal point for these activities, the Office of Beneficiary Services.

With respect to the IG recommendation that the development of an effective "Medicare Part B Advocates Program" should be accelerated, it should be noted that the advocates or peer counseling program has been operational for over a year.

With respect to the recommendation that the availability of beneficiary services be given wider and more frequent publicity in FY 81, we will actively publicize the availability of services directly to beneficiaries. Information will also be directed to the various service sites where beneficiaries access the system.

We intend to explore with SSA and contractors, several options for improving services to beneficiaries in outlying areas.

The IG further recommended that beneficiaries should be increasingly alerted to the threat of Medigap insurance salespersons. Since its development in December, 1979, we have distributed over five million brochures entitled, "Guide to Health Insurance for People with Medicare." This brochure was written jointly by HCFA and the National Association of Insurance Commissioners. HCFA has established a Medigap consumer information campaign as well as a program for training seniors who will counsel their peers on the Medigap issue. The Medigap counselor training program is in effect nationwide.

In addition, and in line with the IG's recommendation, the Explanation of Medicare Benefits has been redesigned, and pretested with beneficiaries and special interest groups.

Finally, we are in the process of actively examining the "reasonable charge" concept of operation with consideration being given to determining charges on a fee-for-service basis.

ITEM 5. (Service Delivery Assessment Recommendations Provided to the Secretary in 1980) Availability of Physician Services to Medicaid Beneficiaries - August, 1980.

ANSWER. The IG recommended that we take steps to promote increased physician participation in Medicaid. Since that time we have intensified our ongoing efforts with States to encourage their increased communication with HCFA providers.

With regard to the recommendation to monitor and upgrade physician-fiscal agent relationships, we will continue to place emphasis on the timely processing of claims in the development of performance standards and monitoring of State administration. We are working with the AMA and other interested parties to develop a system of common claim forms and procedural coding systems to simplify the preparation and payment of physician claims.

ITEM 6. (Service Delivery Assessment Recommendations Provided to the Secretary in 1980) -End Stage Renal Disease Program - June, 1980.

ANSWER. Relative to the recommendation to upgrade the practice of client education, a patient brochure, "Living With End-Stage Renal Disease", was initially developed by the Public Health Service prior to the establishment of HCFA. The brochure deals with the medical aspects of end-stage renal disease. The brochure was very well received by patients and the treatment community; copies of the brochure are in great demand.

Recently it was determined that the brochure needs updating to provide information on recent medical and technical advances such as continuous ambulatory peritoneal dialysis (CAPD). A revision of the brochure is being prepared.

Slide presentations on transplantation and self-care dialysis are being prepared with ESRD patients as the target audience. HCFA is developing a system whereby the slide program can be distributed on a loan basis.

A self-care dialysis training manual for use by patients on home or in center self-care dialysis is in preparation. The training manual was published on October 30, 1981 and distribution has begun.

An ESRD Program fact book for patients is being prepared to provide information on all aspects of the ESRD Program, including the various treatment modalities which are available.

In addition, HCFA is supporting workshops conducted at various ESRD networks designed to promote the use of a "whole life" recordkeeping system. A "whole life" record system is a patient care plan that states patient goals that reflect final measurable outcomes with steps along the way, including staff approaches or strategies to assist the patient with the attainment of goals. In this system, the long-term goal is not solely medical care, but broadly defined health care with all disciplines working together toward the solution of patient problems and needs. Planning in advance for meeting patients' needs reduces time spent on crisis, leading to more effective use of staff time on goal oriented activities.

Activities designed to enhance employment do not fall within the purview of HCFA. However, it should be noted that P.L. 96-265, enacted in June 1980, contains provisions for extension of the trial work period under titles II and XVI. It also authorizes certain income exclusions under title XVI to permit, in many cases, continued Supplemental Security Income payments and Medicaid entitlement to the working blind or disabled. This latter provision is effective only from January 1981 to January 1984, and so is a temporary provision at present. In addition, the Social Security Administration is authorized by this law to carry out some demonstration projects relating, in part, to removing the financial disincentives to work.

Although we do not wish to comment directly on the rehabilitation results of the SDA, we have been given the preliminary findings of a study encompassing about 2,500 patients which indicate that the rehabilitation rate of ESRD patients may be as high as 60 percent.

For the past 2 years HCFA has been conducting a home dialysis aide demonstration project. Under the demonstration, payment is made for the services of a home dialysis aide, or a lesser amount is paid a family member acting as a home dialysis aide. The project will yield valuable information on program costs and ways to encourage the use of home dialysis. Evaluation of the results of the project has already begun.

In the very near future, the target rate reimbursement system for home dialysis will be fully implemented. Under the target rate, which is optional for each facility, a single, per treatment payment will be made for all the items and services needed by a home dialysis patient. The target rate reimbursement system will encourage home dialysis because the facility will be permitted to keep, as profit, the difference between its costs and the target rate payment amount; patients will receive the services of paid assistants, where necessary.

We are taking two actions that will increase the number of approved self-care dialysis facilities and will increase patient participation in their own care. While current regulations do not provide for approving facilities that furnish only self-dialysis, we will consider approval of such facilities when there is sufficient information available to assure the health and safety of patients. We propose to permit self-care dialysis units as part of facilities otherwise approved to furnish self-care dialysis training only.

HCFA will approve self-care dialysis facilities as part of facilities approved to furnish self-care dialysis training only when the regulation that permits the approval of ESRD facilities which furnish self-care dialysis training only, is published in final. The regulation was published as an NPRM on January 15, 1981.

HCFA has developed regulations implementing section 1881 (b)(2)(B) which authorizes incentive reimbursement for dialysis services. The regulation, which is currently in the departmental clearance process, will set identical payments for dialysis whether such services are staff assisted or self-administered by the beneficiary. A single rate will encourage facilities to maximize the use of self-dialysis, which is less costly to the facility.

Although the National Institute of Arthritis, Metabolism and Digestive Diseases, National Institute of Health, has conducted a preliminary literature search on the issue of dialyzer reuse, the safety and efficacy of this procedure has not been established. Until clinical trials have been conducted to prove or disprove the safety and efficacy of the procedure, HCFA should not encourage dialyzer reuse. We plan to conduct a congressionally mandated study in FY 1982 on dialyzer reuse.

ITEM 7. (Service Delivery Assessment Recommendations provided to the Secretary in 1980)- Restricted Patient Admittance to Nursing Homes - August, 1980.

ANSWER. The following activities have been supported and complemented by the recommendations identified by the IG.

Regulations were published on October 1, 1981, to implement case management and home and community care provisions of P.L. 97-35. We are also developing regulations to implement P.L. 97-35 mandating lower reimbursement for hospital beds used by patients while waiting for an available nursing home bed.

In addition, regulations are being developed to implement the swing bed provision of P.L. 96-499 with publication expected shortly.

We are monitoring a demonstration by the National Center for Health Care Statistics regarding incentives for nursing homes to accept heavy care patients and to discharge light care patients. The report is due in 1984.

We have conducted a demonstration project regarding the three-day prior hospitalization rule for Medicare patients. The results show that the elimination of the three day requirement does not affect the cost of the program; but, some of the actuaries that commented said the data's validity is doubtful.

Finally, we recently completed a study, as required by P.L. 96-499, on availability of and need for SNF services covered under Medicare and Medicaid, including investigation of the desirability and feasibility of SNF's participating in either Medicare or Medicaid to participate in both programs. The Report to Congress is in the final stages of preparation.

QUESTION #2 What other changes in program operation have resulted from the IG's recommendations to this date? Please identify by program, date of suggestion (month and year), date of implementation and change.

ANSWER. Apart from those recommendations identified and discussed in connection with our response to question number 1 of this request, the typical IG audit report does not result in "changes in program operation". IG audit reports usually recommend that the State agency or fiscal intermediary change its procedure to comply with existing program operating procedures. In many cases, the definition of an operation is in question; but, no changes in HCFA program operations are required for compliance.

There are approximately 500 such audit reports received annually.

Question #3: Program validation activities are similarly targeted at effecting program change. What changes, if any, in the way programs operate resulted from program validation activities?

Answer: Several major policy and operational changes have resulted from program validation activities. The following is a summary of some major changes.

1. Part A Waiver of Liability Provisions

   Generally providers are not liable for noncovered services unless they have received a specific written notification regarding noncoverage from the UR Committee of the intermediary; have knowledge of noncoverage because of provider manual instructions; or have had some other notification regarding noncoverage. A program validation review recently conducted indicated that some providers who intentionally abused the Medicare program were protected from denial of Medicare payment due to the lack of a prior notification concerning noncoverage. As a result, the Bureau of Program Policy (BPP) has agreed to revise manual instructions to make it clear that waiver of liability provisions do not apply to situations where provider claims are found to be clear cut attempts to defraud or abuse the program.

2. Related Organizations

   Generally, payments made to a provider for services supplied by a related organization are only allowable to the extent of the actual cost incurred by the related organization in supplying the services. A provider may claim reimbursement for the charges made to it by the related organization in lieu of the actual costs incurred by the related organization if the provider has been granted an exception to this "related organization" principle. Only the home office intermediary for the related organization has sufficient information to make a determination on whether an exception to the related organization principle applies. A program validation review uncovered a situation in which a determination, to grant an exception to the related organization principle, was made by the intermediary which serviced the provider even though no such determination had been made by the home office intermediary. The Bureau of Program Policy has agreed to modify the manual instructions in a manner which could prevent an intermediary which is not the home office intermediary from making a determination to grant an exception to the related organization principle.

3. **Physician "Mark-Up" of Tests Performed by Independent Labs**

Frequently, physicians bill the Medicare program for laboratory tests which were actually performed by an independent laboratory. Two program validation reviews pointed out that under existing manual instructions physicians could abuse the Medicare program by billing the Medicare program for a higher amount than the amount charged by the laboratory for performing the test. After the Bureau of Quality Control (BQC) referred this issue to the Bureau of Program Policy for corrective action, a legislative change was made which prohibits a physician from billing the program an amount greater than the amount charged by the laboratory for performing the test (Section 943 of Public Law 97-35, The Omnibus Budget Reconciliation Act of 1981).

4. Post-Operative Surgical Shoes

A validation review in Dallas showed that in a majority of cases, patients admitted to hospitals for podiatric surgery received post-operative surgical shoes which were reimbursed under Medicare. The Bureau of Quality Control pointed out that these shoes are prohibited from Medicare coverage under Section 1862(a)(8) of the Social Security Act. The Bureau of Program Policy has agreed to add this item as a noncovered item in the Coverage Appendix of the manuals.

5. Collection Agency Fees

A validation review performed in Idaho disclosed that because of misunderstanding and misinterpretation of policy, providers were including, as Medicare costs, collection fees even though the provider did not refer any Medicare cases for collection action. The Bureau of Program Policy has corrected this policy deficiency.

6. Reimbursement for Oxygen Concentrators

A validation review conducted on reimbursement for oxygen concentrators showed that in a majority of cases medical documentation was insufficient to determine if the Medicare criteria for reimbursement was met. The Bureau of Program Policy has acknowledged that medical documentation requirements for oxygen concentrators must be strengthened. Pending regulations will correct the problems cited by BQC.

7. Duplicate Medicare Payments

A validation review disclosed that a provider was receiving Periodic Interim Payments (PIP) from its intermediary while at the same time it received duplicate PIP payments from the Office of Direct Reimbursement (ODR). The provider has repaid the excessive payments and a computer modification has been made to prevent future problems.

Question #4: Does anyone in the Bureau of Quality Control (BQC) coordinate and compare the recommendations of program validation, those of the IG, other Departmental recommendations (please specify the Department) and external recommendations? If so, where are these people located within the Bureau? How many people are engaged in this activity?

Answer: Program validation activities planned for each fiscal year are articulated in the Bureau of Quality Control's Annual Audit Plan. Prior to each fiscal year, a draft audit plan is circulated to the Office of the Inspector General (OIG), as well as to the General Accounting Office (GAO), State Medicaid Agency officials, and Health Care Financing Administration (HCFA) contractors. Suggestions for validation reviews are solicited from these entities, and the OIG and GAO are asked to indicate what program validation activities may overlap recent or planned OIG or GAO studies. To avoid any possible duplication of effort and wasted resources, program validation activities that overlap planned OIG or GAO reports are usually deleted from the Audit Plan. Through comments received from the entities above with respect to the Audit Plan, the audit resources of OIG, GAO, and BQC are coordinated.

There is no entity within BQC which has the specific responsibility to coordinate and compare the recommendations of program validation, OIG, other Department recommendations, and external recommendations. Therefore, there is no specific staff or number of people routinely engaged in this activity. The coordination of audit planning mentioned above ensures that there will not be inappropriate duplication of audit efforts. When BQC becomes aware of OIG or GAO studies that have similar findings and recommendations to program validation reports, these studies are cited with the program validation report when recommendations are referred to other HCFA components for action.

Question #5: Once an OI investigation is terminated by the Justices declination and returned to BQC, what is the Bureau's process for tracking the case and assuring other appropriate remedies are considered? What mechanism is employed? Is there a central control point? Who has this responsibility?

Answer: Once an Office of Investigations (OI) investigation is terminated by the Justice Department's declination, the Division of Quality Control (DQC) in the Health Care Financing Administration (HCFA) regional office (RO) assumes responsibility for assuring that all other appropriate remedies are considered. Appropriate remedies may include: the recovery of any overpayments; consideration of possible administrative sanction (termination, exclusion); or, as requested by OI, pursuance of the case through civil action.

The Division of Quality Control in each HCFA RO maintains its own case control system for all cases referred to OI. Strict controls are maintained on each case to ensure that administrative stanctions, if appropriate, are initiated. When the RO forwards a case to OI, it informs OI of the administrative sanctions which could be taken and that these sanctions will proceed unless OI instructs the RO, in writing, within 45 days, not to proceed. If OI has not provided a written notice of objection within 45 days of the referral, administrative sanctions will be considered and appropriate sanction activity initiated. If OI does provide written notice of objection to the RO, sanction development will be delayed until after the prosecution action or the investigation is completed. Any case that is declined by a U.S. Attorney and returned to the RO by OI will be reviewed to ensure that appropriate administrative sanctions or other appropriate remedies are pursued.

All cases returned to the RO due to the Justice Department's declination which necessitate administrative remedies (recovery of overpayment, administrative sanction development, civil action) are tracked on individual case reporting forms and are reported to BQC centrally. Each case returned from OI that necessitates some administrative action is reported on a separate case reporting form. Although each HCFA RO is responsible to ensure that appropriate remedies are considered in all cases returned from OI, all appropriate remedies will be reported and tracked by BQC through the case reporting process. Tracking these cases is the responsibility of the Office of Program Validation (OPV) in BQC.

Where a RO recommends administrative sanction (termination, exclusion) in a case, its recommendation and background information are forwarded to the Provider Administrative Sanctions and Appeals Branch, OPV, BQC. The Office of Program Validation is responsible for reviewing the RO's recommendations and effectuating any appropriate administrative sanctions.

Question #6: You were asked to come prepared to specify the administrative and civil sanctions that followed OI action in the 41 health cases presented for prosecution in 1980. What action has been taken on these cases? Please specify by case number and indicate action taken and date.

Answers: The action taken on the 41 cases is detailed in the attached tables. In addition to the 41 cases presented to the Department of Justice by OI, we have provided you with information on 29 cases referred by the Office of Program Integrity to the Inspector General and subsequently to the Department of Justice. (Because no case numbers are identified on the OI cases, cases on our tables are referenced to the list of the 41 cases you previously provided to us, which is attached.)

We have summarized this information into the following seven categories:

1.	Administrative sanction imposed	5
2.	Overpayment recouped	14
3.	Cases closed - insufficient evidence for sanction	20
4.	Cases pending final action by HCFA	18
5.	Duplicate entries	6
6.	Cases not received by HCFA	4
7.	Cases pending with IG or U.S. Attorney	3
	TOTAL	70

OFFICE OF INVESTIGATIONS HEALTH CARE CASES REFERRED TO DOJ IN CY 80

REGION - BOSTON

Page	Line Item	Identification	Action Taken and Status
1	1	Lawrence Marowitz, DPM	Criminal fraud case pending with OI-New York office but case not expected to result in referral to U.S. Attorney for criminal prosecution. RO using podiatry consultant to review claims for overpayment and sanction. RO expects to refer case for civil fraud and administrative sanction prior to 3/1/82.
1	2	Maple Hill Ambulance AMB	Business was sold in 7/80. No sanction due to sale. Company was on prepayment review from 9/79 - 8/80. Overpayment for years 1976-1980 calculated at $2300. U.S. Attorney has agreed to pursue civil fraud to recoup O/P and administrative costs. RO expects to complete case development and refer to U.S. Attorney prior to February 1982.
1	3	Joseph P. Lamanna, MD	Carrier requested to conduct postpayment review and establish overpayment or recommend sanction action. Carrier is to report to RO by 12/31/81. Final action pending.
1	4	Mayfair Medical and Ambulance AMB	Overpayment of $2000 determined for years 1976-1979. Since 1979 provider has submitted no questionable claims. U.S. Attorney has agreed to pursue civil fraud to recoup O/P and other costs. RO expects to complete case development and refer to U.S. Attorney prior to February 1982.
4	1	Alice Wynett BENE	Beneficiary fraud. U.S. Attorney declined case as there was no loss to the Government. Case closed.
4	2	Milton Medical Lab LAB	Companion cases. Criminal and civil aspects declined by U.S. Attorney. Provider on prepayment review since 1977. In May 1981, RO instructed carrier to review current claims for possible O/P and sanction. RO evaluation of carrier review will be completed in January 1982. Carrier holding $37,000 in claims reimbursement to offset possible overpayment.
4	3	Milton Randolph Lab LAB	
4	4	Clifford Farmer, POD	Suspended for 1 year beginning 8/21/80. Reinstatement requested and Dr. Farmer reinstated effective 11/3/81.

OFFICE OF INVESTIGATIONS HEALTH CARE CASES REFERRED TO DOJ IN CY 80

REGION - NEW YORK

Page	Line Item	Identification	Action Taken and Status
2	5	Samuel Goldberg	2/79 case referred to OI 5/80 USAT declined prosecution 7/80 RO case closed due to insufficient evidence 9/80 $89 overpayment recouped by carrier
2	6	Robert Schwartz	Referred to OI 3/79. USAT declined 1/80. No action planned - 70 year old provider - 2 instances of improper billing - total Medicare payments to doctor $900 per year
2	7	Carl Cultraro	Referred to OI 4/79. USAT declined 9/80. RO currently investigating.
2	8	Noel Handel	Referred to OI 5/79. USAT declined 4/80. RO currently investigating.
2	9	Roy Miller	Case file has never been in RO (OI initiated)
2	10	Paul Costanzo	Referred to OI 10/79. USAT declined 5/80. RO currently investigating.
2	11	Amarjit Jolly	Referred to OI 2/80. Never referred back to RO as of 11/25/81.
4	5	Hudson Medical Assoc.	This case has never been in the Office of Program Integrity
4	6	George Stevens/Regina Massey	Referred to OI 7/78. USAT declined 2/80. Overpayment of $252 - collected $209 thus far. RO closed case in 1/81 due to insufficient evidence and low earnings.
4	7	Assoc. Amb.	Being developed by OPI for administrative sanction action
4	8	Endicot Rental	Referred to OI 4/79. USAT declined 5/80. RO closed sanctic case due to insufficient evidence. Overpayment of $9139 established--recouped $1332 thus far.

OFFICE OF INVESTIGATIONS HEALTH CARE CASES REFERRED TO DOJ IN CY 80

REGION - NEW YORK

Page	Line Item	Identification	Action Taken and Status
4	9	Ira Goldman AA Amb. Corp.	Being developed by OPI for sanction or overpayment
4	10	Noel Handel	Duplicate of page 2, line item 8
4	11	Robert Schwartz	Duplicate of page 2, line item 6
4	12	Jack Becker	Referred to OI 1/80. USAT declined 11/80. Closed due to insufficient evidence. Overpayment - $29,663 - recouped $3,703 thus far
4	13	Artco Amb. (Cultraro)	Duplicate of page 2, line item 7
4	14	Band B Systems	OPI developing for possible sanction action
5	15	Metropolitan Amb.	OPI developing for possible sanction action
5	16	Paul Costanzo	Duplicate of page 1, line item 11
5	17	Albany Surgical	Referred to OI 12/78. USAT declined 2/80. RO closed due to insufficient evidence. Overpayment is $623.65 - $313 recouped thus far
5	18	Raphel Cestero	File has never been in the Office of Program Integrity OI case exclusively
5	19	Charles Akslerad	Referred to OI 5/80. USAT declined 5/80. RO closed case due to insufficient evidence. Overpayment - $224.32 recouped.
5	20	Samuel Goldberg	Duplicate of page 1, line item 5

OFFICE OF INVESTIGATIONS HEALTH CARE CASES REFERRED TO DOJ IN CY 80

REGION - PHILADELPHIA

Page	Line Item	Identification	Action Taken and Status
1	12	Albert Tompkins	Referred to Washington, D.C. fraud control unit by State agency on 10/23/80. Medicaid case. Results of investigation not received by HCFA. 6/15/81 - case still under State investigation.
1	13	Oxford Circle Ambulance	Out of business since 1979 - no sanction action. Unable to recoup O/P.
1	14	Belmont Pharmacy	6/26/80 referred to carrier for O/P calculation 11/24/80 followup survey - no longer taking assignment. No current investigation going on. (O/P of $2356 recouped)

OFFICE OF INVESTIGATIONS HEALTH CARE CASES REFERRED TO DOJ IN CY 80

REGION - ATLANTA

Page	Line Item	Identification	Action Taken and Status	
2	1	Julio Menache	8/4/80	Received from carrier - billing for services not rendered
			9/8/80	Referred to OI
			10/15/80	Declined by US Attorney - O/P less than $50 - not recouped - Sanction not applicable - no pattern
2	2	Michael A. Rush	5/78	Referred to OI
			10/15/80	Declined by US Attorney - but was incorporated into another fraud case still under investigation by OI and FBI
2	3	Philip Toyama	1/79	Received from carrier - misrepresenting acupuncture as covered service
			6/4/79	Referred to OI
			9/10/79	Referred to US Attorney
			5/21/80	US Attorney declined
			6/17/80	Returned to RO
			9/3/81	Sanction case declined by CO - insufficient evidence Carrier dealt with claims through manual processing - no cumulative O/P
2	4	Tennessee Home Health Care, Inc.	10/5/79	Received from intermediary - related organization not disclosed on cost report
			10/26/79	Referred to OI
			4/10/80	Declined by US Attorney - lack of criminal intent
			4/16/80	Returned to RO
			5/14/80	Intermediary determined no adjustment necessary re cost report
			8/80	Further administrative sanction ruled out due to insufficient evidence - case closed
2	5	Frierson (owner) and Dooley (adm.) (Oakview Nursing Home)	3/31/80	Referral from BQC, Baltimore - requiring payment as precondition for admission
			4/10/80	RO closed inquiries - not Medicare provider
			7/15/80	OI conducting investigation and so advised HCFA RO

OFFICE OF INVESTIGATIONS HEALTH CARE CASES REFERRED TO DOJ IN CY 80

REGION - ATLANTA

Page	Line Item	Identification	Action Taken and Status
5	7	Memphis Eye and Ear	7/7/78 Received from intermediary - including nonreimbursable costs in cost reports 7/12/79 OI - Memphis instructs RO to continue investigation (via phone call) 6/16/79 OI referred case to US Attorney via telephone - case declined 8/13/79 Returned to RO 1/80 RO referred to US Attorney for civil action - declined. However US Attorney accepted case criminally and directed OI to open another fraud case 2/1/80 RO requested by US Attorney to furnish additional information on reimbursement 2/19/80 Additional information furnished
5	8	Public Convalescent Ambulance	12/4/78 Received from carrier 3/79 Assignment privileges suspended 5/17/79 Referred to OI 9/28/79 Referred to US Attorney 6/19/80 Declined by US Attorney 6/24/80 Returned to RO 6/26/80 Referred to US Attorney for civil Civil complaint filed - pending 6/5/81 Assignment suspension lifted - principals no longer associated with day to day operations Exclusion of 3 principals in development stage
5	9	Amorette Drury	3/23/79 Received from carrier - Field survey by RO 10/31/79 Preliminary discussions with US Attorney 5/28/80 Referred formally to US Attorney 4/13/81 Declined by US Attorney - bene. deceased - low money amount
5	10,11	Jimmy Lee Laster Liddie Mae Laster	8/22/80 Received from carrier 12/16/80 Referred to US Attorney (confession from Jimmy) 2/4/81 Declined by US Attorney Carrier has recouped $450 of $1100 O/P Bene. flagged for manual review

OFFICE OF INVESTIGATIONS HEALTH CARE CASES REFERRED TO DOJ IN CY 80

REGION - ATLANTA

Page	Line Item	Identification	Action Taken and Status
5	12	Effie Goodwin	2/79 Received from carrier 1/30/80 Referred to US Attorney 6/25/80 Declined by US Attorney - O/P ($156.80) recovered Bene flagged for manual review

OFFICE OF INVESTIGATIONS HEALTH CARE CASES REFERRED TO DOJ IN CY 80

REGION - CHICAGO

Page	Line Item	Identification	Action Taken and Status
2	20	Action Ambulance, AMB	No PI involvement; case opened due to complaint arising from HHS audit; OI referred to USAT 2/80; case closed 1/19/81 - allegations unable to be confirmed
2	21	Johnson Chu, M.D.	PI sent closed file to OI 2/80; OI returned file 11/80; closed by OI 11/10/80 with notation that no criminal or civil fraud was present; no record of case ever being sent to USAT - case closed by RO due to insufficient evidence on 11/10/80.
2	22	Richard Wells, D.P.M.	Recommendation to suspend being processed. (Anticipated effectuation in January 1982)

OFFICE OF INVESTIGATIONS HEALTH CARE CASES REFERRED TO DOJ IN CY 80

REGION - DALLAS

Page	Line Item	Identification	Action Taken and Status
2	24	Stephen's Friendship Manor, SNF	First investigation closed by OI. Second investigation resulted in conviction in 3/81, sentenced on 6/15/81. RO considering sanction under section 1128 when regulations are published in January 1982 (i.e., expands prior suspension provisions to include nursing home administrators or operators). Title XIX only facility.
2	25	Windsor Hills Health Care Facility, SNF	OI and State agency case. Title XIX only. RO considering nursing home owner for suspension under section 1128 when regulations are published in January 1982.
2	26	Kitty Barrett, DME	OI investigation revealed no fraud - USAT declined case. OI critical of HCFA procedures regarding DME suppliers. Southern Respiratory Care repaying O/P of $38,829 - beginning 12/80. Kitty Barrett not connected with O/P. No sanction potential - case closed.

OFFICE OF INVESTIGATIONS HEALTH CARE CASES REFERRED TO DOJ IN CY 80

REGION - Kansas City

Page	Line Item	Identification	Action Taken and Status
2	27	Montgomery Investment Corporation	Criminal prosecution by USAT in progress in Kansas City. No declination ever received, no OPI involvement.
2	28	Douglas County Hospital	Fraud detected as part of Program Validation review. Case referred to OIG. No criminal prosecution. Overpayment of $697,000 recouped by State agency.
5	27	Douglas County Hospital	Duplicate of line item 2-28 above.
5	28	William Martin	Administrative sanction not warranted based upon facts of case. No overpayment.

OFFICE OF INVESTIGATIONS HEALTH CARE CASES REFERRED TO DOJ IN CY 80

REGION - DENVER

Page	Line Item	Identification	Action Taken and Status
3	29	National Health Lab	Referred to OI 10/78. Returned to RO 6/80. RO closed case on 6/10/80 due to insufficient evidence regarding kickback.
3	30	Guy A. Richards, M.D.	Prosecution declined 4/80. In 10/80 carrier collected overpayment of $589.80.
3	31	O. E. Corbin, POD	Referred to OI 12/78. Returned to RO 4/80. Case closed 6/16/80 due to lack of evidence regarding upgrading of services or overutilization.
3	32	Jeffray Mechanik, DPM	Referred to OI 3/79. Returned to RO 5/80. Case closed 6/15/80 due to lack of evidence regarding upgrading of services or overutilization. O/P of $1581 recouped in 9/80.
3	33	Roland Fleck, M.D.	Referred to OI 5/79. USAT declined 4/11/80. RO closed case 8/80 due to lack of evidence regarding misrepresentation. No overpayment.
3	34	Buel Hutchinson, M.D.	Suspended for 3 years beginning 11/12/81 based upon criminal conviction in 8/80.
3	35	M. J. Berlin, DPM	Referred to OI 9/79. Declined by USAT 5/80. Returned to RO 6/80. Case closed 12/4/80 due to lack of evidence regarding upgrading of services or overutilization. No overpayment.
3	36	Frank Gillespie (St. Joseph's Hospital)	Case received on 6/2/80, closed by regional office 7/25/80. USAT indicated there was no financial benefit to the individual and therefore no basis for an exclusion.
2	23	E & E Ambulance, AMB	Referred to OI 11/78. USAT declined 12/80. Returned to RO 12/29/80. Closed in 1/81 due to lack of evidence regarding misrepresentation. No overpayment.

OFFICE OF INVESTIGATIONS HEALTH CARE CASES REFERRED TO DOJ IN CY 80

REGION - SAN FRANCISCO

Page	Line Item	Identification	Action Taken and Status
4	17	Jack Segao (Segal)	Carrier suspended payments in 1978 when case was referred to OI. Since that time there is no record of him billing the program.
4	18	Jesus Nunez	RO sent case to CO with recommendation that Nunez be excluded - Nunez excluded for 10 years on 1/26/81.

OFFICE OF INVESTIGATIONS HEALTH CARE CASES REFERRED TO DOJ IN CY 80

REGION - SEATTLE

Page	Line Item	Identification	Action Taken and Status
3	19	Jerry Williams, M.D.	Opened by Washington State MFCU; USAT recommended verbally to PI to accept Special Prosecutor's offer of including Medicare money with their case; USAT "declined" - no fraud; PI and Washington Physicians' Services (carrier) reviewed beneficiary records in 3/81 - $283 O/P; WPS medical director determined onsite services were in fact rendered - no O/P; PI closed case 5/81
3	20	Wasyl Adkins, SNF	Involved cost reports for nursing home; opened by Washington State MFCU; USAT declined - no dollar loss to Medicare
3	21	James & Johanna Leyde, AMB	Excluded 8/7/81 (2 years)
5	29	James Yu, M.D.	O/P being determined; suspended 1/30/79 (1 year); reinstatement denied 6/18/80

OFFICE OF INVESTIGATIONS

HEALTH CARE CASES REFERRED TO DOJ IN CY-80

#	Judicial District	Class	Nature of Offense	Date Referred to U.S. Attorney	Date of Indictment	Date of Conviction	Date of Declination	Status Pending Further Investigation
1	CT	DPM	Billing for services not rendered.	7/80	Marowitz, Lawrence		7/80	Closed
2	CT	AMB	Billing for services not rendered.	4/80	Maple Hill Ambulance		4/80	Closed
3	PA	MD	Billing for services not rendered.	11/80	Lemanna, Joseph P.		11/80	Closed
4	CT	AMB	Billing for services not rendered.	5/80	Mayfair Medical & Ambulance		5/80	Closed
5	NJ	MD	Billing for services not rendered.	2/80	Goldberg, Samuel		2/80	Closed
[illegible]	S-NY	MD	Billing for services not rendered.	1/80	Schwartz, Robert		1/80	Closed
7	S-NY	MD	Duplicate billings.	10/80	Cultraro, Carl		10/80	Closed
[illegible]	S-NY	DPM	Billing for services not rendered.	3/80	Handel, Noel		3/80	Closed
9	NJ	SNF	Kickbacks.	2/80	Miller, Roy C.			Pending Decision
7	[illegible]	POD	Billing for services not	3/80	Costanzo, Paul		5/80	Closed
11	E-NY	MD	Billing for services not	8/80	Jolly, Amarjit J.			Pending Decision
4	[illegible]	MD	Billing for services not	3/—	Tompkins, Albert R		5/80	Closed
3	E-PA	AMB	Billing for services not	4/80	Oxford Circle Ambulance		4/80	Closed
4	E-PA	PHAR	Billing for drugs not supplied.	4/80	Behmont Pharmacy		4/80	Closed

APPENDIX B
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OFFICE OF INVESTIGATIONS

HEALTH CARE CASES REFERRED TO DOJ IN CY-80

Case #	Judicial District	Class	Nature of Offense	Date Referred to U.S. Attorney	Date of Indictment	Date of Conviction	Date of Declination	Status Pending Further Investigation
15	S-FL	MD	Billing for services not rendered.	10/80	Menache, Julio		10/80	Closed
16	S-FL	DPM –	Billing for services not rendered.	10/80	Rush, Michael A		10/80	Closed
17	M-NC	MD	Misreporting services.	9/80	Toyawa, Phillip M.		9/80	Pending Civil
18	E-TN	HHA	False cost reporting.	3/80	Tennessee Home Health Care, Inc		4/80	Closed
19	M-TN	SNF	False cost reporting.	7/80	Dooley, Frierson (Oakview Nursing Home)			Pending Decision
20	N-IL	AMB	Billing for services not	2/80	Action Ambulance			Pending Decision
21	N-IN	MD	False claims.	11/80	Chu, Johnson		11/80	Closed
22	N-IL	DPM	Billing for services not rendered.	5/80	10/80	12/80	Wells, Richard	Closed
23	CO	AMB	False claims.	12/80	E & E Ambulance		12/80	Closed
24	W-OK	SNF	False cost reporting.	4/80	Stephens Friendship Manor		4/80	Closed
25	W-OK	SNF	False cost reporting.	3/80	* 9/80	9/80		Closed
26	E-AK	DME	Kickbacks.	6/80	Barrett, Kitty		6/80	Administrative
27	E-MO	SNF	Perjury.	1/80	* 10/80*		10/80	Pending Civil
28	NE	HOSP	False claims.	3/80	Douglas County Hospital		8/80	Closed

* 25 Windsor Hills Health Care Facility
27 Montgomery Investment Corp.

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OFFICE OF INVESTIGATIONS

HEALTH CARE CASES REFERRED TO DOJ IN CY-80

ID #	Judicial District	Class	Nature of Offense	Date Referred to U.S. Attorney		Date of Indictment	Date of Conviction	Date of Declination	Status Pending Further Investigation
	CO	LAB	Billing for services not rendered.	3/80	National Health Lab			3/80	Closed
	UT	MD	Billing for services not rendered.	4/80	Richards, Guy A.			4/80	Closed
	CO	POD	Billing for services not rendered.	4/80	Corbin, O.E.			4/80	Closed
	CO	DPM	False claims.	4/80	Mechanik, Jeffrey			4/80	Closed
	SD	MD	Billing for services not rendered.	7/80	Fleck & Ashley			7/80	Closed
	CO	MD	Billing for services not rendered.	4/80	Hutchinson, Buel	6/80	8/80		Closed
	CO	DPM	Billing for services not rendered.	4/80	Berlin, M. J.			5/80	Closed
	MT	HOSP	Billing for services not rendered.	4/80	Gillespie, Funk (St. Joseph's Hospital)			4/80	Closed
	C-CA	LAB	Billing for services not rendered.	6/80	Segao, Jack L.			7/80	Closed
	C-CA	DME	Billing for services not rendered.	8/80	Nunez, J. (Adept Prosthetics)			8/80	Closed
	W-WA	MD	Billing for services not rendered.	7/80	Williams, Jerry			7/80	Closed
	E-WA	SNF	Billing for services not rendered.	1/80	AdKins, Wasyl			1/80	Closed
	W-WA	AMB	Billing for services not rendered.	4/80	Leyde, Jim & Jo			4/80	State Conviction (10/80)

APPENDIX B
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Office of Program Integrity (HCFA)
Cases Referred to the U.S. Attorneys
Calendar Year 1980

Case #	Judicial District	Class	Nature of Offense	Date Referred to U.S. Attorney	Date of Indictment	Date of Conviction	Date of Declination	Status Pending Further Investigation
1	Massachusetts	BENE	False claims.	1/80				Pending Decision
2	Massachusetts	LAB	False claims.	1/80				Pending Decision
3	Massachusetts	LAB	False claims.	1/80				Pending Decision
4	Connecticut	POD	False claims.	3/80				Pending Decision
5	Newark, NJ	CLINIC	Duplicate billing.	1/4/80			1/4/80	
6	Newark, NJ	HDS	Billing for services not rendered.	2/21/80			2/21/80	
7	New York	AMB	Billing for services not rendered. Misrepresenting services.	6/3/80			6/3/80	
8	New York	DME	Billing for services not rendered.	5/17/80			5/17/80	
9	New York	AMB	Misrepresenting services.	5/27/80			5/27/80	
10	New York	POD	Billing for services not rendered.	4/11/80			4/11/80	
11	New York	MD	Billing for serivces not rendered.	1/31/80			1/31/80	
12	New York	MD	Billing for services not rendered.	11/21/80			11/21/80	
13	New York	AMB	Duplicate billing.	9/29/80 Returned			9/29/80	
14	New York	DME	Billing for services not rendered.	9/29/80			9/29/80	

APPENDIX
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Office of Program Integrity (HCFA)
Cases Referred to the U.S. Attorneys
Calendar Year 1980

Case #	Judicial District	Class	Nature of Offense	Date Referred to U.S. Attorney	Date of Indictment	Date of Conviction	Date of Declination	Status Pending Further Investigation
15	New York	AMB	Misrepresenting services.	9/2/80			9/2/80	
16	New York N-District	MD	Billing for services not rendered.	5/15/80			5/15/80	
17	New York W-District	DME	Billing for services not rendered.	2/1/80			2/1/80	
18	New York W-District	MD	Billing for services not rendered.	2/20/80			2/20/80	
19	Newark, NJ	MD	Misrepresenting services.	5/22/80			5/22/80	
20	Newark, NJ	MD	Billing for services not rendered.	5/22/80			5/22/80	
21	Tennessee	HOSP	False claims.	1/31/80			1/31/80	
22	S. Georgia	AMB	False claims.	6/27/80				Pending Decision
23	Georgia	BEN	False claims.	5/29/80				Pending Decision
24	S. Alabama	BENE	False claims.	12/16/80				Pending Decision
25	S. Alabama	BENE	False claims.	12/16/80				Pending Decision
26	N. Florida	BENE	False calims.	1/24/80			6/25/80	
27	Nebraska	HOSP	Duplicate billing.	5/27/80			8/19/80	
28	Kansas	DO	Misrepresenting services.	7/29/80			7/29/80	
29	E-Washington	MD	False claims.	2/12/80				Pending Decision

Chairman **Heinz**. Well, without cbjection, your entire statement will be made part of the record.

[The prepared statement submitted at the hearing follows:]

STATEMENT BY MARTIN KAPPERT

DEPUTY ASSOCIATE ADMINISTRATOR

FOR OPERATIONS

HEALTH CARE FINANCING ADMINISTRATION

SUMMARY

- HCFA IS COMMITTED TO ERADICATING FRAUD, ABUSE, AND WASTE IN FINANCING HEALTH PROGRAMS FOR THE NATION'S ELDERLY AND POOR.
- OUR FIRST PRIORITY IS TO MONITOR HEALTH CARE PAYMENTS AND TO DETECT INAPPROPRIATE PAYMENTS QUICKLY THROUGH SPECIFIC PROGRAMS WHICH INCLUDE:
  - MEDICAID MANAGEMENT INFORMATION SYSTEM
  - MEDICAID QUALITY CONTROL SYSTEM
  - COST REPORT EVALUATION SYSTEM
  - PART B QUALITY ASSURANCE PROGRAM
  - VALIDATION REVIEW PROGRAM
  - ASSESSMENT OF MEDICARE CONTRACTOR AND MEDICAID STATE AGENCY PERFORMANCE PROGRAM
- IF FRAUD OR ABUSE IS SUSPECTED, MEDICARE CONTRACTORS AND STATE AGENCIES INVESTIGATE.
- IF THE INVESTIGATION IDENTIFIES POTENTIAL FRAUD BY PROVIDERS, REFERRAL IS MADE TO:
  - THE OFFICE OF THE INSPECTOR GENERAL FOR MEDICARE FRAUD CASES
  - FOR MEDICAID FRAUD, EITHER THE STATE MEDICAID FRAUD CONTROL UNIT, OR THE APPROPRIATE STATE LAW ENFORCEMENT AGENCY IF THERE IS NO STATE FRAUD CONTROL UNIT.
- ONCE FRAUD OR ABUSE IS DETECTED, IN ADDITION TO REFERRAL FOR PROSECUTION AND EFFORTS TO RECOVER OVERPAYMENTS, WE USE OUR ADMINISTRATIVE SANCTIONS PROGRAM TO PUNISH THE OFFENDER THROUGH SUSPENSION OR EXCLUSION FROM PARTICIPATION IN MEDICARE AND MEDICAID.
- WE HAVE WELCOMED THE CONTRIBUTIONS OF THE INSPECTOR GENERAL'S AUDITS AND SERVICE DELIVERY ASSESSMENTS IN OVERSIGHT OF HEALTH EXPENDITURES.

Chairman Dole, Chairman Heinz, and Committee Members:

I am Martin Kappert, Deputy Associate Administrator for Operations of the Health Care Financing Administration. I am pleased to be with you today to discuss HCFA's efforts to combat fraud, abuse and waste in the Medicare and Medicaid programs.

The Medicare and Medicaid programs which HCFA administers provide health insurance coverage for 28 million aged and disabled individuals plus 22.5 million beneficiaries eligible for Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI). Thus our programs touch the lives of more than 50 million Americans -- 1 in every 5, or about 22 percent of the total population of the United States.

The goal of assuring the integrity of health care financing programs for the nation's elderly and poor is a fundamental concern to us as it is to you. Fraud, as you are aware, is

OBTAINING SOMETHING OF VALUE UNLAWFULLY THROUGH WILLFUL MISREPRESENTATION. ABUSE IS EXCESSIVE USE OF SERVICES OR IMPROPER PRACTICES WHICH ARE NOT PROSECUTABLE. WASTE MAY BE DEFINED AS MISSPENT DOLLARS ARISING FROM DEFICIENT PRACTICES, MANAGEMENT SYSTEMS, OR CONTROLS. IN A TIME WHEN EVERY DOLLAR COUNTS, WE CANNOT AFFORD TO SPEND CAREFULLY BUDGETED HEALTH CARE FUNDS ON UNNECESSARY -- OR WORSE -- FRAUDULENT ACTIVITIES. THAT IS WHY HCFA IS COMMITTED TO ERADICATING FRAUD, ABUSE AND WASTE IN THE EXPENDITURE OF GOVERNMENT FUNDS.

WE AT HCFA INTEND TO BE SURE THAT PROGRAM PAYMENTS ARE PROVIDED ONLY TO ELIGIBLE BENEFICIARIES FOR APPROPRIATE SERVICES, AND AT REASONABLE RATES. THIS REQUIRES THAT SOPHISTICATED CONTROLS BE AN INTEGRAL PART OF OUR EVERYDAY OPERATIONS.

WE HAVE A NUMBER OF SPECIFIC PROGRAMS TO MONITOR HEALTH CARE PAYMENTS, AND TO DETECT INAPPROPRIATE PAYMENTS QUICKLY.

o MEDICAID MANAGEMENT INFORMATION SYSTEM

THE MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) HAS BEEN A PARTICULARLY EFFECTIVE TOOL IN IMPROVING STATE MANAGEMENT OF MEDICAID EXPENDITURES. MMIS ENABLES STATES TO EFFICIENTLY PROCESS CLAIMS AND CONTROL PROGRAM EXPENDITURES. THE SYSTEM ALSO GENERATES DATA FOR THE STATES WHICH IDENTIFY INSTANCES OF PROGRAM ABUSE IN THE MEDICAID PROGRAM.

CURRENTLY 36 STATES, ACCOUNTING FOR ABOUT THREE-QUARTERS OF MEDICAID EXPENDITURES, HAVE FULLY CERTIFIED MMIS SYSTEMS. TEN OTHER STATES ARE DEVELOPING MMIS SYSTEMS, AND ONLY 5 STATES HAVE NOT INITIATED DEVELOPMENTAL EFFORTS TO INSTALL AND TAKE ADVANTAGE OF THE CAPABILITIES OF MMIS.

THE POSITIVE RESULTS OF EXISTING MMIS ACTIVITIES DEMONSTRATE ITS EFFECTIVENESS. FOR EXAMPLE, MICHIGAN HAS ESTIMATED THAT THE MMIS ENABLED THE STATE TO SAVE MORE THAN $30 MILLION IN 1978 FROM THE REJECTION OF DUPLICATE CLAIMS, THE DENIAL OF CLAIMS FOR INELIGIBLE BENEFICIARIES, AND THE RECOVERY OF FUNDS FROM THIRD PARTIES.

o MEDICAID QUALITY CONTROL

WE HAVE ESTABLISHED A COMPREHENSIVE MANAGEMENT SYSTEM--THE MEDICAID QUALITY CONTROL (MQC) SYSTEM--WHICH COMPLEMENTS THE MMIS AND ASSISTS IN IMPROVING THE MANAGEMENT OF THE MEDICAID PROGRAM.

THE MQC SYSTEM REVIEWS A SAMPLE OF CASES TO IDENTIFY ERRORS AND INCORRECT PAYMENTS, DETERMINE THE REASONS FOR THESE ERRORS, AND PRODUCE DATA WHICH CAN BE USED TO INITIATE CORRECTIVE ACTIONS.

THIS STATE-ADMINISTERED, FEDERALLY-DESIGNED MANAGEMENT SYSTEM IS SPECIFICALLY DESIGNED TO REDUCE ERRONEOUS MEDICAID PAYMENTS RESULTING FROM ERRORS IN ELIGIBILITY DETERMINATION, CLAIMS PROCESSING, AND DETERMINATION OF THIRD-PARTY LIABILITY. FEDERAL PROGRAM COSTS WERE REDUCED AN ESTIMATED $68.2 MILLION IN FY 1980 AS A RESULT OF THIS ACTIVITY.

THE IMPROVEMENT OBSERVED IN MANY STATES' ERROR RATES BASED ON THE MQC SYSTEM IS CERTAINLY COMMENDABLE. FOR EXAMPLE, 20 STATES, INCLUDING MANY OF

THE LARGEST STATES, HAVE REDUCED THEIR MOST RECENT ERROR RATES FROM THE PREVIOUS SIX-MONTH MONITORING PERIOD. ALTHOUGH THE NATIONAL RATE IS STILL HOVERING AROUND THE 5 PERCENT LEVEL, THERE IS A GREAT DEAL OF VARIABILITY FROM STATE TO STATE. WE ARE OPTIMISTIC, HOWEVER, THAT MOST STATES WILL ACHIEVE THE CONGRESSIONALLY MANDATED TARGET OF 4 PERCENT BY THE END OF FY 1982.

- COST REPORT EVALUATION SYSTEM

IN THE MEDICARE PROGRAM, OUR COST REPORT EVALUATION PROGRAM (CREP) AIDS IN THE ASSESSMENT OF MEDICARE INTERMEDIARY PERFORMANCE AND HCFA POLICY IN THE SETTLEMENT OF PART A HOSPITAL AND HOME HEALTH AGENCY COST REPORTS. THE PROGRAM IS DESIGNED TO REVIEW A CASH FLOW OF APPROXIMATELY $27 BILLION. THIS IS ACCOMPLISHED THROUGH SAMPLING ALL HOSPITAL AND HOME HEALTH AGENCY COST REPORTS SETTLED BY MEDICARE INTERMEDIARIES DURING A FISCAL YEAR. CREP HAS PROVEN TO BE EXTREMELY VALUABLE IN SURFACING PROBLEMS RELATED TO REIMBURSEMENT POLICIES. IT HAS ALSO HELPED TO IDENTIFY ERRORS IN CLAIMS REVIEW. THE ESTIMATED SAVINGS FROM RECOVERIES FOR FY 1981 ARE IN EXCESS OF $6 MILLION.

- Part B Quality Assurance Program

  In addition, our Part B Quality Assurance Program detects payment errors in the Medicare Supplemental Insurance Program. It reduces the likelihood of future errors occurring by reviewing claims processed by Medicare carriers, identifying their sources and making appropriate corrections. As a result of the reductions in payment and deductible errors, savings for fiscal 1981 are estimated at approximately $18 million.

For both Medicaid and Medicare, we have instituted management systems to enable us to monitor fiscal agents rsponsible for expenditure of our funds, including our validation review program and our program of assessment of Medicare contractor and Medicaid State agency performance. I would like to describe each of these systems for you.

- Validation Review Program

  Our program validation efforts are intended to assure the appropriateness of claims payments under Medicaid and Medicare, as well as to test the effectiveness of existing program policies and

OPERATIONS. WE ACCOMPLISH THIS THROUGH AUDIT ATTENTION TO VARIOUS AREAS WHERE THERE IS A POTENTIAL FOR MISSPENT FUNDS--EITHER BECAUSE OF PRACTICES ON THE PART OF INDIVIDUAL OR GROUPS OF HEALTH CARE PROVIDERS WHICH SUGGEST THAT A CLOSER EXAMINATION MAY BE REQUIRED, OR BECAUSE WE ARE CONCERNED THAT OUR POLICIES MAY NEED REVISION OR OUR OPERATIONS MAY NEED TO BE IMPROVED.

o ASSESSMENT OF MEDICARE CONTRACTOR AND MEDICAID STATE AGENCY PERFORMANCE

BECAUSE OUR PROGRAMS ARE ADMINISTERED THROUGH OTHER ORGANIZATIONS AND AGENCIES, WE EVALUATE AND MONITOR THE EFFECTIVENESS OF MEDICARE CONTRACTORS AND MEDICAID STATE AGENCIES IN IDENTIFYING, INVESTIGATING, AND TAKING ACTION ON SUSPECTED CASES OF FRAUD AND ABUSE. WE ALSO PROVIDE TECHNICAL ASSISTANCE AND SERVE A COORDINATING FUNCTION BETWEEN MEDICARE AND MEDICAID TO IMPROVE THE PERFORMANCE OF CONTRACTORS AND STATES.

IN ADDITION TO ACTIVITIES TO MAINTAIN THE OVERALL EFFICIENCY OF OUR PROGRAM OPERATIONS, HCFA HAS A MAJOR ONGOING RESPONSIBILITY TO IDENTIFY AND REDUCE IMPROPER PRACTICES BY INDIVIDUAL HEALTH CARE PROVIDERS. ONE OF OUR MOST IMPORTANT TOOLS FOR

THIS IDENTIFICATION IS THROUGH ABUSE INVESTIGATIONS AND PRELIMINARY FRAUD INVESTIGATIONS.

MEDICARE CONTRACTORS AND MEDICAID STATE AGENCIES ARE REQUIRED TO INVESTIGATE SITUATIONS--IDENTIFIED THROUGH CLAIMS PROCESSING SYSTEMS OR OTHER MEANS--WHICH INVOLVE SUSPECTED FRAUD, ABUSE, OR OTHER IMPROPER PRACTICES. IN THESE CASES THEY DETERMINE WHETHER THERE HAVE BEEN SPECIFIC VIOLATIONS OF THE LAW OR PROGRAM REQUIREMENTS AND ASCERTAIN THE AMOUNT OF ANY PROGRAM OVERPAYMENTS WHICH HAVE RESULTED. IF THE INVESTIGATION IDENTIFIES POTENTIAL CRIMINAL FRAUD BY PROVIDERS, REFERRAL IS MADE TO THE OFFICE OF THE INSPECTOR GENERAL FOR MEDICARE FRAUD CASES, AND EITHER THE STATE MEDICAID FRAUD CONTROL UNIT OR, WHERE THERE IS NO STATE FRAUD CONTROL UNIT, THE APPROPRIATE STATE LAW ENFORCEMENT AGENCY, IF THERE IS POSSIBLE MEDICAID FRAUD. THESE BODIES CONDUCT ANY FURTHER INVESTIGATION AND WORK WITH THE DEPARTMENT OF JUSTICE AND STATE PROSECUTORIAL AGENCIES ON THE CASE.

ONCE FRAUD OR ABUSE ARE DETECTED, WE MUST BE ABLE TO TAKE ACTION TO SANCTION THE OFFENDER, WE ACCOMPLISH THIS THROUGH OUR ADMINISTRATIVE SANCTIONS PROGRAM.

THESE SANCTIONS SUPPLEMENT REFERRAL FOR PROSECUTION, AND EFFORTS TO RECOVER ANY OVERPAYMENTS. ACTION MAY BE INITIATED

TO SUSPEND OR EXCLUDE THE PROVIDER'S PARTICIPATION IN MEDICARE AND MEDICAID. WE MAY ALSO PROVIDE INFORMATION TO THE RELEVANT STATE LICENSURE BOARD FOR APPROPRIATE ACTION.

THE PREVENTION AND DETECTION FUNCTIONS I HAVE REVIEWED WITH YOU ARE DISTRIBUTED IN SEVERAL COMPONENTS THROUGHOUT HCFA, PRIMARILY THE BUREAUS OF QUALITY CONTROL AND PROGRAM OPERATIONS, AS WELL AS IN THE REGIONAL OFFICES. TOGETHER, SUBSTANTIAL TIME IS DEVOTED TO FRAUD AND ABUSE THROUGHOUT HCFA ON THESE ACTIVITIES. IN ADDITION, MEDICARE CONTRACTORS AND MEDICAID STATE AGENCIES ALSO HAVE INDIVIDUALS WHOSE WORK IS DEVOTED TO AUDIT AND RELATED ACTIVITIES DESIGNED, AT LEAST IN PART, TO DETECT AND ADJUDICATE INSTANCES OF PROVIDER AND PATIENT ABUSE AND FRAUD.

GIVEN THE COMPLEXITIES OF OUR PROGRAMS AND THE MAGNITUDE OF OUR EXPENDITURES, WE WELCOME THE CONTRIBUTIONS THE DEPARTMENT'S OFFICE OF THE INSPECTOR GENERAL HAS MADE TO CURB FRAUD, ABUSE AND WASTE IN HEALTH CARE FINANCING PROGRAMS.

THE INSPECTOR GENERAL'S OFFICE HAS SUPPORTED STATE MEDICAID FRAUD CONTROL UNITS, WHICH ARE NOW OPERATING IN 29 STATES. DURING 1980, THE EFFORTS OF THESE UNITS RESULTED IN 366

INDICTMENTS AND 196 CONVICTIONS. AT THE END OF 1980, THERE WERE 2035 CASES PENDING AND UNDER INVESTIGATION.

THE OFFICE OF THE INSPECTOR GENERAL ALSO CONDUCTS AUDITS, PROGRAM REVIEWS, AND SERVICE DELIVERY ASSESSMENTS AIMED AT IMPROVING DEPARTMENT OPERATIONS. IN 1980, THE INSPECTOR GENERAL ISSUED 748 REPORTS RELATED TO HEALTH EXPENDITURES UNDER HCFA'S JURISDICTION, AND RECOMMENDED FINANCIAL ADJUSTMENTS TOTALLING $37.3 MILLION. THE TYPES OF FINDINGS WHICH WERE IDENTIFIED INCLUDE: 1) OVERSTATED CLAIMS--$11.8 MILLION IN MEDICAID AND $7.9 MILLION IN MEDICARE; 2) INELIGIBLE CLAIMS--$3.8 MILLION AND $5.1 MILLION; AND 3) PROCEDURAL VIOLATIONS--$2.3 MILLION FOR MEDICARE AND MEDICAID.

WE HAVE UNDERTAKEN A NUMBER OF ACTIONS IN RESPONSE TO THE INSPECTOR GENERAL'S RECOMMENDATIONS. AS A RESULT OF ALL AUDIT REPORTS ISSUED TO DATE, WE HAVE RECOVERED $126 MILLION, WITH 109 CASES STILL PENDING. IN ADDITION TO FINANCIAL RECOVERIES, WE HAVE ALSO RESPONDED TO THE REPORTS BY INITIATING REVIEWS OF VARIOUS POLICIES AND PROCEDURES, PLANNING TO COMPLETELY REVISE OTHER REGULATIONS, AND WORKING WITH THE IG TO INITIATE NEW AUDITING APPROACHES.

WE HAVE HAD A SYSTEM FOR TRACKING RECOMMENDATIONS FROM THE INSPECTOR GENERAL AND THE GENERAL ACCOUNTING OFFICE REGARDING FINANCIAL ADJUSTMENTS IN PLACE FOR SOME TIME, AND WE HAVE RECENTLY INSTITUTED A COMPARABLE SYSTEM FOR MONITORING MANAGEMENT RECOMMENDATIONS AS WELL. WE HAVE ALSO ESTABLISHED TIMETABLES FOR FOLLOW-UP AND RESOLUTION OF RECOMMENDATIONS.

I HOPE THAT I HAVE BEEN ABLE TO DESCRIBE FOR YOU OUR EFFORTS TO PREVENT, DETECT, AND PUNISH FRAUD, ABUSE, AND WASTE IN OUR PROGRAMS, AS WELL AS OUR WORK WITH THE OFFICE OF THE INSPECTOR GENERAL IN THESE AREAS. FURTHER INFORMATION REGARDING AREAS OF PARTICULAR INTEREST TO THE COMMITTEES IS ATTACHED TO MY FORMAL STATEMENT. I WILL BE HAPPY TO RESPOND TO ANY QUESTIONS YOU MAY HAVE.

ATTACHMENT 1

HCFA ACTIVITIES RESPONSIVE TO RECOMMENDATIONS MADE BY THE INSPECTOR GENERAL DURING 1980*

REPORT		HCFA ACTIONS
Audit	Management of Personal Care Services Under Title XIX	Preparing recommendations to more clearly define circumstances under which such services may be provided
Audit	Need for More Restrictive Policies and Procedures for Medicare Reimbursement of Hospital-Based Physicians	March 1, 1980 published notice in Federal Register that provisions of 42 CFR 405.832 and 42 CFR 405.483(a) would be uniformly enforced, thus generally precluding reasonable charge reimbursement for clinical laboratory services furnished to Medicare patients in hospitals and skilled nursing facilities Lawsuit subsequently challenged legal effect of notice and HCFA was preliminarily enjoined from implementing its intent October 6, 1981 - HCFA withdrew previous notice Recommended modifications to the existing regulations will be published in Federal Register early in 1982
Audit	Requirements for Teaching Physicians to Qualify for Reimbursement Under Medicare and Medicaid	Developing proposed regulations to implement Section 948 of P.L. 96-499, regarding a new method for determining the customary charges for physician services in a teaching setting, to be published by June, 1982
SDA	Medicare Part B Beneficiary Services	Conducted an expanded beneficiary information program publicizing the availability of beneficiary services Met with Social Security Administration to explore options for improving services to beneficiaries in outlying areas Prepared and distributed a brochure entitled "Guide to Health Insurance for People with Medicare"

*Includes HCFA activities ongoing or underway which were reinforced by the Inspector General's recommendations.

REPORT		HCFA ACTIONS
SDA	Medicare Part B Beneficiary Services (Continued)	Established a consumer information campaign and nationwide counselor training program on supplemental health insurance for Medicare beneficiaries
SDA	Availability of Physician Services to Medicaid Beneficiaries	Intensified ongoing efforts with States to encourage increased communication between State Medicaid programs and providers, including physicians
		Developed revisions to Medicaid Management Information System to include data on physician participation
		Working with the AMA and other interested parties, developed a common claim form for physician use under Medicaid and Medicare which has now been adopted by a majority of State Medicaid programs
		Experimenting with use of a common procedure coding and developing long range strategy for encouraging use of common procedure codes
SDA	ESRD	Accepted bids from interested parties to revise a popular PHS patient brochure entitled "Living with End Stage Renal Disease" to reflect recent medical and technical advances
		Prepared slide presentations on transplantation and self-care dialysis to be loaned to patients
		Prepared and distributed a training manual on self-care dialysis
		Prepared an ESRD program fact book providing information on all aspects of the program
		Supported workshops conducted by ESRD networks to promote a "whole life" recordkeeping system in which patients develop step-by-step plans to meet their medical and other goals enabling them to deal more constructively with the problems imposed by their illness

REPORT		HCFA ACTIONS
SDA	ESRD (Continued)	Developed a rule, now in final stages, to permit approval of ESRD facilities which furnish self-care dialysis training only. This would encourage more self-care training programs
		Is chairing a Departmental task force which will be advising the Secretary on ESRD policy issues
		Is revising data collection system to secure more comprehensive and usable data regarding services received by ESRD beneficiaries
SDA	Restricted Patient Admittance to Nursing Homes	Published regulations to implement case management and home and community care provisions of P.L. 97-35
		Developing regulations to implement P.L. 97-35 mandating lower reimbursement for hospital beds used by patients while waiting for an available nursing home bed
		Developing regulations to implement swing bed provision of P.L. 96-499. Regulations will be published shortly
		Monitoring demonstration by National Center for Health Care Statistics regarding incentives for nursing homes to accept heavy care patients and to discharge light care patients; report due 1984
		Conducted a demonstration project regarding the three-day prior hospitalization rule for Medicare patients
		Completed study, as required by P.L. 96-499, on availability of and need for SNF services covered under Medicare and Medicaid, including investigation of desirability and feasibility of SNFs participating in either Medicare or Medicaid to participate in both programs. Report to Congress in final preparation

ATTACHMENT 2

ADMINISTRATIVE SANCTIONS TAKEN ON CASES REFERRED TO UNITED STATES ATTORNEYS BY THE INSPECTOR GENERAL IN 1980

Sanction	Cases
Administrative sanction imposed	5
Overpayment recouped	14
Cases closed - insufficient evidence for sanction	20
Cases pending final action by HCFA	18
Duplicate entries	6
Cases not received by HCFA	4
Cases pending with IG or U.S. Attorney	3
	70

ATTACHMENT 3

ALLOCATION OF STAFF RESOURCES DEVOTED TO THE PREVENTION OF ABUSE AND WASTE IN THE MEDICARE AND MEDICAID PROGRAMS FOR FY 1981

Activities	Purpose F/A/W*	Total Staff Central	Total Staff Regional	$ Resources**
Medicaid Management Information System (MMIS)	A & W	9	22	$1,147,000
Medicaid Quality Control (MQC)	W	28	135	6,031,000
Cost Report Evaluation Program (CREP)	A & W	5	51	2,072,000
Part B Quality Assurance Program	W	4	33	1,369,000
Validation Review Program	A & W	21	105	4,662,000
Assessment of Medicare Contractor & Medicaid State Agency Performance	W	66	211	10,249,000
Abuse Investigation	A	3	56	2,183,000
		136	613	
TOTAL			749	$27,713,000

* F/A/W means Fraud, Abuse and Waste.

** Resources Assumption: Average Annual Salary and Benefits per employee: $37,000.

STATEMENT OF NELSON SABATINI, EXECUTIVE ASSISTANT TO THE COMMISSIONER, SOCIAL SECURITY ADMINISTRATION

Mr. SABATINI. Mr. Chairman, Commissioner Svahn has made a very strong commitment to reducing the incidence of fraud, waste, and abuse and also to recovering money that have been misspent when these incidents do occur.

I would like to just give you a brief overview of some of the things that we are doing in social security to reduce fraud, waste, and abuse.

One of the first things that we have done is to order a significant increase in the number of continuing disability investigations that we undertake to insure that individuals who are receiving benefits based on disability are actually disabled.

We have expanded our program of risk assessments to identify those areas in which the SSA system has its greatest vulnerability.

We are working to develop an interface with the Internal Revenue Service to assist us in identifying undisclosed assets and resources.

We have expanded our quality measurement activities to foster error reduction and to include a comprehensive picture of the accuracy of the SSA payments and the causes of error.

An additional effort that we are devoting a great deal of resources to and which complements our fraud, waste and abuse efforts is to increase the collection of outstanding debts owed to the Agency. Currently there is outstanding debt of approximately $1.9 billion and we are attempting to increase our collections over the next 2 years by nearly $1 billion. We plan to do this by emphasizing our philosophy that we want debts to be paid and paid quickly. We are instituting management controls over all our debts. We are collecting debts at the earliest opportunity. We are making efforts to resolve delinquent accounts.

We see our debt collection initiative as a complementary activity to our commitment to reduce fraud, waste and abuse. Both stem from an overall commitment to insure that all program expenditures are lawful and necessary.

I would be happy to answer any questions.

Chairman HEINZ. Mr. Sabatini, thank you. And we will make your entire statement, which is quite lengthy, a part of the record.

[The prepared statement of Nelson Sabatini follows:]

STATEMENT OF
NELSON SABATINI
EXECUTIVE
ASSISTANT TO THE
COMMISSIONER
SOCIAL SECURITY ADMINISTRATION

Messrs. Chairman and Committee Members:

My name is Nelson Sabatini, Executive Assistant to the Commissioner of Social Security. Commissioner Svahn has asked that I represent him at today's hearing.

The Social Security Administration is committed to preventing, and reducing the incidence of, fraud, waste, and abuse and to recovering the monies misspent when these incidents occur. Our aim is to prevent, detect, and recover misspent monies. We also investigate cases of fraud and, when appropriate, refer them for prosecution.

As you know, the Social Security Administration is responsible for administering the Old-Age and Survivors Insurance (OASI), Disability Insurance (DI), and Supplemental Security Income (SSI) programs. In FY 1981 we distributed $143 billion in payments to nearly 40 million Americans. SSA also oversees State administration of the Aid to Families with Dependent

Children (AFDC) program. With programs of this magnitude a relatively low rate of incorrect payments translates to a significant dollar figure.

I will now review the payment accuracy systems that SSA operates, describe recent findings, and explain current efforts toward further improving payment accuracy. I might note at the outset that unintentional errors significantly exceed fraud as a cause of misspent dollars.

To give you some idea of how small percentages may correspond to large amounts of dollars, the payment accuracy rate in the retirement and survivors program for the last measured period (April-September 1979) was 99.72 percent. The corresponding error rate of .28 percent resulted in about $124 million in incorrect payments in this 6-month period. Obviously, it is well worth our while to work to improve our accuracy. Of the $124 million error in the OASI program, over one-half was paid to student beneficiaries. With the recently enacted legislation that will phase out post-secondary student benefits by 1985, we expect to see a significant improvement in retirement and survivors insurance payment accuracy. Most of the remaining errors are attributable to changes in beneficiary circumstances such as unreported marriages and divorces. SSA is currently studying these errors to determine ways to reduce their occurrence. (Errors due to inaccurate reporting of earnings are not included in the error rate for this period; they will be included in the study now underway for the October 1979-March 1980 period.)

SSA has only recently implemented a quality measurement system for Social Security disability insurance payments similar to that for retirement and survivors payments. Therefore, we do not yet have a comparable accuracy rate for these payments. Based on a pilot test we conducted in developing this new system, we believe that the disability insurance error rate may be 20 percent or more. Due to the potential magnitude of the

DI error rate, SSA has accelerated its review of current disability cases. The Social Security Disability Amendments of 1980 (P.L. 96-265) require SSA to conduct a triennial review of continuing disability cases beginning in January 1982. However, SSA began an accelerated review in March of this year. We are also reviewing 35 percent of favorable disability decisions prior to initial payment and concentrating this review on high-error-prone cases. These reviews, along with procedural changes we are making to expedite terminations of cases being ceased, should serve to reduce the DI error rate.

For the Supplemental Security Income (SSI) program, the payment accuracy rate for the most recent measured period (October 1980-March 1981) is 94.7 percent. This represents $219 million misspent over this 6-month period. Although the SSI accuracy rate has improved significantly since the beginning of the program in 1974 when it was about 87 percent, it has remained relatively stable in recent years. The early improvement resulted from implementing actions that affected the payments of a large number of recipients, such as a computer system match with Title II master beneficiary records and Veterans Administration records. A current SSI initiative is to establish an interface with Internal Revenue Service data on interest income as a lead to identifying bank account errors, the largest source of SSI errors.

Is is important to note that the SSI quality review on which the accuracy figures are based has never included a review of disability factors for disabled recipients. Therefore, the accuracy rate is overstated. As in the Title II disability program, we believe the error rate on disability factors may be 20 percent or more. We expect to establish an ongoing review of disability factors for SSI cases in 1982.

With respect to the Aid to Families with Dependent Children (AFDC) program, the accuracy rate has steadily increased over the past 2 years from 90.6 percent to 92.7 percent. During this time SSA has devoted considerable resources to helping States in developing plans to correct errors. In particular, SSA is assisting States in developing techniques whereby error case data is analyzed in such a way as to provide a "profile" of error-prone cases. When cases with a high probability of error can be selected out, State resources can be used most efficiently by directing attention to those cases.

I would now like to describe how these activities relate to the Office of the Inspector General (OIG). The Office of the Inspector General (OIG) has been supportive of SSA error reduction activities. In particular, OIG audits and initiatives on Social Security number fraud and on death record matching operations to identify erroneous payments to deceased beneficiaries have been beneficial across program lines. It is in the area of fraud detection and processing, however, that the OIG and SSA work most closely. As I suggested earlier, a very small percent of misspent monies is due to fraud. SSA and OIG have an operating agreement under which OIG retains responsibility for investigating employee fraud cases and SSA assumes responsibility for investigating most beneficiary fraud cases. However, in addition to this activity, SSA has taken efforts directed to fraud prevention and detection within the agency. SSA has instituted a Systems Security program directed at identifying and correcting those aspects of SSA processes vulnerable to fraud. This program entails conducting risk assessments (i.e., reviews of processes and systems to identify vulnerabilities), development of security plans for each SSA component, enhancement of automated data processing security, and an increased awareness on the part of SSA employees as to the need to be alert to potential security violations.

Before I conclude, I would like to take a moment to discuss an effort that complements prevention and detection of fraud, waste, and abuse. I am referring to debt collection. In April of this year, President Reagan directed executive branch departments and agencies to implement aggressive debt collection programs. Commissioner Svahn has set this as one of his top priorities. SSA's outstanding debt is approximately $1.9 billion. A new debt collection program is underway that will increase the net amount of debt collected in FY 1982 and FY 1983 by nearly $1 billion over what otherwise would have been collected. This will be accomplished by immediately taking the following actions:

One, by emphasizing our philosophy that debts be paid and paid quickly.

Two, by instituting management control of all debts, both in our field offices and through automated capabilities.

Three, by collecting debts at the earliest opportunity.

Four, by making efforts to resolve delinquent debts. Special in-house collection units will be established and a pilot test is planned to determine the most efficient way to use private collection agencies and credit bureaus.

Finally, by developing billing, followup and management information systems. During FY 1983 an agencywide accounts-receivable system will be established.

SSA views its debt collection initiative as a complementary activity to its commitment to reduce fraud, waste, and abuse. Both stem from an overall commitment to ensure that all program expenditures are lawful and necessary.

Thank you for this opportunity to discuss SSA's efforts to combat fraud, waste, and abuse. Attached are specific responses to the questions the Committee directed to SSA.

Attachment

1. What specific actions were taken by SSA in response to recommendations made by the Inspector General during 1980?

   A. Audit Number 13-02608—Review of Procedures for Reimbursing GSA from Non-Recurring Reimbursable Work Authorizations

   B. Unnumbered—Assessment of Problems Found in the Computer Process of SS Enumeration System

   C. Audit Number 15-90250—State Practices on Refunding the Federal Portion of Recovered Overpayments

   D. Audit Number 13-12614—Review of Title II Benefit Payment Withdrawals and Disbursements by SSA

   E. Audit Number 12-13076—Review of Internal Controls Over Payment of Overtime

   F. Unnumbered—Service Delivery Assessment

      —Low Income Energy Assistance Program (LIEAP)

A. Report Title: Review of Procedures for Reimbursing GSA for Non-Recurring Reimbursable Work Authorizations (Audit Number 13-02608, March 31, 1980)

Overview : This report notes that when SSA requests repairs or improvements, GSA does not contract for the work until after it has received payment from SSA for the estimated cost. For FY 75-78 projects, the trust funds could have earned $447,000 in interest if payment had been made upon project completion rather than when requested.

Recommendation:

That SSA submit a proposal to GSA requesting 1) waiver of the advance payment requirement, and 2) approval to reimburse GSA on a percentage of completion basis for non-recurring work authorizations.

Action:

SSA moved promptly to implement this recommendation. We immediately requested a wiaver and got GSA to agree in principle. The procedures SSA recommended to GSA called for 1) not advancing cash until the project actually begins and 2) GSA providing periodic cost reports to SSA. Progress payments under each reimbursable work authorization would be compared to actual costs and refunds requested where 1) advances are excessive or 2) projects are terminated before their completion. Essentially, the arrangement proposed by SSA provides cash flowing to GSA to coincide with its level of need. After a one year delay GSA has now promised that the necessary new billing procedures will be issued and implemented in January 1982. SSA's finance and realty and space management staffs will coordinate oversight of costs and cash flow once GSA implements its new procedures.

Recommendation:

That SSA issue procedures for 1) monitoring actual costs of non-recurring projects to determine when refunds of excess payments should be requested from GSA, and 2) requesting prompt refunds for excess payments on projects terminated before their completion or completed at amounts less than the payments to GSA.

Action:

We have instituted a standard set of procedures to ensure greater oversight in the monitoring of costs. These procedures require GSA to submit cost breakdowns, shop drawings, and cost amendments to SSA prior to the granting of funding authorization. In addition, the procedures proposed to GSA in response to the first recommendation contained a request for refund when advances are excessive or projects terminated prior to completion.

B. Report Title: Assessment of Problems Found in the Computer Process of the Enumeration System (attachment to Shiela Brand's June 25, 1980, letter to Ted Murcheck)

Overview : Shiela Brand of OIG participated in a risk assessment of the enumeration (social security card issuance) process that was conducted by SSA during 1980. The "vulnerabilities" identified by Ms. Brand were included in the risk analysis report, which was published by SSA's Office of Enumeration and Earnings Records in February 1981. These recommendations were not addressed by SSA separately, but as part of the overall risk analysis report.

Most of the recommendations in Ms. Brand's letter dealt with specific operational problems involving the processing of applications for social security cards. The enumeration process that was studied by Ms. Brand's risk analysis team will be replaced shortly by a greatly modified process, whereby social security number applications will be keyed into the system by local field offices, rather than being mailed into Baltimore. As a result, many of these recommendations will no longer be applicable. Others will continue to be relevant, however, and we are currently either working on implementation of those or analyzing them further to determine the best course of action.

The recommendations made by Ms. Brand were combined into the following nine safeguard recommendations in the overall risk analysis report:

Recommendation:

Change the electronic process to control and follow-up on exceptions produced by the system to ensure that all are reentered.

Action:

With the implementation of the modified process, the reentry of exceptions will become a district office (DO) responsibility, and the problem cited will not apply.

Recommendation:

Reexamine all edit routines and improve as necessary.

Action:

The modified enumeration process described above has required a new set of edit routines, since the initial input is coming from a different source. The new edit routines will be upgraded.

Recommendation:

The edit check of the district office (DO) code field should require a valid DO code.

Action:

The new process will automatically pick up the DO telecommunication address from the data communications terminal (called the hardware address); thereby eliminating the reported problem.

Recommendation:

Expand edit routines to identify all errors in a record rather than rejecting an input record as soon as the first error is discovered.

Action:

The modified process will contain this capability.

Recommendation:

Maintain a backup copy of the master tape files, including each day's transactions, in an area removed from the data center.

Action:

SSA uses a secure, off-site, underground storage facility to store its master tape files and is developing a contingency plan that will ensure rapid recovery should something happen to all or part of the master files housed on magnetic media.

Recommendation:

The tape file that contains the actual SSN cards to be printed each night should contain the number of such records to be printed, contain internal checks to make sure no more than that number are printed, and produce information on these figures for management review.

Action:

These requirements are being analyzed by our systems components and will be incorporated in future systems changes.

Recommendation:

A code should be printed on the SSN card and the stub and stored in the electronic record to enable association should an investigation involving the record be necessary.

Action:

SSA has a long term effort underway to establish security audit trails (e.g., who handled an action, when, where, etc.). Unfortunately, these audit trails are expensive to establish and maintain. Our intent is to develop them for cash payment type transactions first, and if it proves cost effective, to apply them to SSN transactions.

Recommendation:

The SSN master record should indicate if the SSN card was returned by the Postal Service as undeliverable.

Action:

The modified process will provide this facility. Such information could be useful in resolving subsequent problems with an account. This capability will not be present upon initial implementation of the modified process, but there are plans to add it shortly thereafter.

Recommendation:

Improve the management information produced by the enumeration system.

Action:

The modified process will produce more usable information about the enumeration operations.

C. Report Title: States Practices in Refunding Federal Portion of Recovered Overpayments and Uncashed Checks Under the AFDC Program (Audit Number 15-90250, June 30, 1980)

Overview: The report notes that States' laws (and policies) vary considerably on the issues of 1) voiding State-issued checks that are not cashed by the beneficiaries, and 2) crediting the Federal programs for their share of these uncashed checks. In some States uncashed checks are voided after 60 days of issuance, while in other States the period is 5 years--or longer. Moreover, voiding or cancelling the checks doesn't necessarily result in refunds to the Federal program.

Recommendation:

Establish an overall uniform policy for timely return of the Federal portion of uncashed checks and other credits. Six months or less from date of issuance should be established as the time allowable for States to return the Federal portion of uncashed AFDC checks.

Action:

We alerted all of our regional offices to this recovery problem and they reviewed States' handling of uncashed checks--how long each one allows checks to remain outstanding; what types of follow-up the States have, if any, to determine the reasons for checks not being cashed. We then initiated action on a new Federal regulation to establish a uniform requirement for States to credit the Federal government for its portion of uncashed AFDC checks. A Notice of Decision to Develop Regulations for this purpose was published in the Federal Register in November 1980. We expect final regulations to be issued in mid-1982.

D. **Report Title:** Review of Title II Benefit Payment Withdrawals and Disbursements (Audit Number 13-12614, October 15, 1980)

Overview: The Audit Agency (AA) calculated that amounts transferred from the Trust Funds to the Treasury to cover monthly title II benefit payments exceeded the amounts actually needed by some $53 million a month. The AA concluded that SSA could increase interest earnings of the Trust Funds by $4.5 million a year if more precise methods of determining the amounts needed were used. In addition the auditors thought more needed to be done to resolve the difference between the payments certified to Treasury and the computer system accounting totals.

Recommendation:

Require the program service centers (PSC's) to promptly prepare and transmit to the Division of Finance via telecommunications or similar equipment, the Daily Reports of Benefit Activity (forms SSA-2049).

Action:

This recommendation has been implemented. The PSC's are now transmitting the forms SSA-2049 to the Office of Management and Budget's Division of Finance on a daily basis via the telecommunications equipment (Facsimile Telecopier).

Recommendation:

Determine needed Trust Funds withdrawals by utilizing daily benefit data recorded on the forms SSA-2049.

Action:

This recommendation has been implemented. Trust Fund withdrawals are now being made using the data contained on the forms SSA-2049.

Recommendation:

Coordinate with the Treasury Department the procedures needed to effect Trust Funds drawdowns on an "as needed" rather than weekly basis.

Action:

We have coordinated with Treasury and, since November 1, 1980, we have been making daily withdrawals from the Trust Funds effective with the date of actual benefit activity as shown on the SSA-2049s received from the program service centers. We contact Treasury daily to inform them of the necessary withdrawal amount.

Recommendation:

Ensure that the causes of the imbalance identified in comparing accounting systems totals to payment data forwarded to the Treasury are documented.

Action:

Although we agree that the method of documenting imbalance conditions needs improvement, the complexity of the changes that would be necessary to accomplish the redesign of the system are too great compared to the benefits to justify inclusion of the redesign as a priority item in SSA's 1982 ADP Plan. The redesign will compete with other projects for later inclusion in the ADP Plan.

Recommendation:

Analyze the causes for the imbalances and take action needed to correct the system to avoid their recurrence.

Action:

With few exceptions we identify the causes of all imbalance conditions. When the cause is identified, immediate action is taken to correct the program so as to prevent further occurrence of any erroneous processing.

Recommendation:

Automate the manual balancing operation currently performed by the Payment Certification and Accounting Unit in Office of Central Operations.

Action:

The balancing operation has been extensively automated. As a result the number of employees involved in the operations has been drastically reduced; at the present time only five accounting technicians are required to handle that part of the operation which remains non-automated.

Present non-automated processes exist only because the data is created in separate and unrelated computer systems. As new systems are developed, we will make every attempt to make them compatible so as to ultimately arrive at a fully automated data collection, balancing, certification, and reporting system. However, such systems will have to be included in SSA's ADP Plan and, although the project has wide acceptance, it is currently impossible to project when it will be included in the plan due to competing priorities.

E. Report Title: Follow-Up Review of Internal Controls Over Payment of Overtime (Audit Number 12-13076, January 1980)

Overview: This review, done at Secretary Schweiker's request, is a follow-up to an OIG report issued in December 1980 critical of HHS overtime practices and controls. In this new report, addressed to the Assistant Secretary for Personnel Administration, OIG notes that improvements have been made in requesting, approving and documenting overtime, but problems persist relating to 1) absence of written requests and approvals of overtime, 2) unsigned authorization forms, 3) inadequate or no documentation for overtime and 4) overtime worked at home. The report also concludes that inadequacies remain in the separation of time and attendance duties. SSA is mentioned as having overtime authorization practices that are inconsistent with Department guidelines.

Action:

Although the audit report and its recommendations were directed to the Assistant Secretary for Personnel Administration, SSA took prompt action on it and on the Secretary's February 1981 directive on overtime. SSA's actions included:

--conduct of the internal compliance reviews as directed by the Secretary;

--issuance of reminders to managers on overtime policies;

--development of a new training program in video cassette format for timekeepers;

--development of a checklist for certifying officers to assist them in fulfilling their responsibilities;

--revising instructions to supervisors on premium pay;

--preparing new redelegations for authorizing overtime;

--redesigning sign-in sheets to accommodate the new requirement for written approval by the secondline supervisor for individuals to work overtime;

--dissemination of time and attendance management reports to assist managers in monitoring individual employee overtime usage and compliance with tour of duty hour limitations.

F. Title : **Low Income Energy Assistance Program (LIEAP) A Service Delivery Assessment (June 16, 1980)**

Overview: The LIEAP was enacted to assist low income people with the increased costs of energy during the winter months. This service delivery assessment was conducted to provide client and local provider feedback on the operation of this new program. Further, it was to provide early warnings of problems in the implementation of LIEAP and to identify major issues for future program considerations. The report deals primarily with the Special Energy Allowance and Energy Assistance Program portions of LIEAP.

Recommendations:

This particular SDA did not make any specific recommendations though it did raise a number of specific issues. These issues were addressed by Congress in its enactment of the Home Energy Assistance Act of 1980 (title III, P.L. 96-223). SSA subsequently took action by its publication of FY 1980 LIEAP regulations. The sections listed below address the effect of those regulations and the remedial action taken by SSA on the issues raised by the FY 1980 SDA affecting fraud, waste, and abuse.

Action:

--In FY 1981 the States had to take into account the specific energy costs of an eligible household in computing benefit amounts (206.154). This provision addressed the concern that in FY 1980 categorical programs were not targeting aid to fuel bills.

--In FY 1981 households within any State were to receive similar amounts of assistance if they were similarly situated with respect to energy costs, income, and other considerations relevant to assistance (260.154). This provision addressed the concern that in FY 1980 similarly situated eligible households in a State were receiving different amounts of payments.

--In FY 1981 home energy suppliers receiving assistance payments on behalf of eligible households were required to sign agreements with their States (unless exempted) which provided assisted households with certain assurances (260.250). States were required to monitor such agreements with home energy suppliers and to secure documentation of energy supplied to eligible households (260.64). These provisions addressed the concern in FY 1980 that better ways be found to insure fuel vendor accountability.

--In FY 1981 States were required, to the maximum extent possible, to refer eligible LIEAP households to existing Federal, State, and local weatherization and conservation services (260.58). This provision addressed the concern in FY 1980 that more coordination of services was needed.

--In FY 1981 States were required to report on a variety of LIEAP program expenditures, including administrative costs (260.82). In part, such fiscal reporting allows for the possibility of identifying cost-effective approaches to LIEAP service delivery as supported by the FY 1980 SDA.

2. **What Specific Administrative Sanctions Have Been Taken by SSA on Income Security Cases Referred to U.S. Attorneys by the Office of Inspector General During 1980?**

We do not have details readily available regarding sanctions taken by SSA on cases referred by the Office of Inspector General to the U.S. Attorneys. I assure you, however, that appropriate administrative sanctions have been taken where such action is permitted and warranted.

The administrative steps available to SSA with regard to beneficiaries are:

- The withholding of up to 3 months' benefits for failure to report events affecting continued entitlement to social security benefits;

- The reduction of supplemental security income payments by as much as $100 for repeated failures or delays in reporting events relevant to eligibility or amount of benefits;

- The suspension or termination of benefits under either program when eligibility factors are no longer met;

- The recovery of overpayments or other improper payments under either program.

The latter two actions are the most likely steps applicable to cases that had been presented to U.S. Attorneys. Where the fraudulent receipt of benefits is established such payments are terminated and recovery actions are initiated either through the criminal or civil divisions of the U.S. Attorneys office or directly by SSA. In this regard, SSA has recently adopted a more aggressive posture with respect to overpayment recovery including the establishment of specific debt collection units, tighter management control over the collection process and specific guidelines for the more aggressively pursuing recovery of overpayments. In our fraud prevention initiative, we have emphasized the need to aggressively pursue the recovery of overpayments resulting from fraud either by seeking restitution as part of the criminal or civil justice process or by issuing demand letters to the overpaid party.

Of course, when it is determined that an SSA employee has violated his or her position of trust, appropriate disciplinary action--including reprimands, reduction in grade, or termination of service--is taken. These actions, which generally result in termination from Federal service for those convicted of crimes against SSA, are imposed in accordance with regulations issued by the Office of Personnel Management.

3. What specific activities such as program validation or program integrity within SSA combat fraud, waste, and abuse? Describe the units and the personnel resources available.

Over the years, the Social Security Administration has established a series of checks and balances (both manual and automated) within its multiple payment systems that are designed primarily to prevent fraud, waste, and abuse. However, the potential for fraud by employees and private citizens always exists in any large payment system involving some 85,000 employees, about 40 million retirement, survivors, disability, and supplemental security income beneficiaries and over 7 million applicants annually.

Where fraud is suspected, either SSA or the Inspector General (IG) in the Department of Health and Human Services investigates the case and, if fruad is involved, refers the case to the U.S. Attorney for prosecution. In general, SSA investigates external cases while the IG investigates all internal fraud cases. External cases generally are those where a person fraudlently establishes benefit entitlement or conceals changes in circumstances that would reduce or terminate benefits. Internal fraud usually involves an employee working alone, or with members of the public to manipulate the system to obtain funds illegally. Where necessary, other law enforcement agencies may be involved, depending on the nature of the case.

Office of Assessment

Fraud, waste, and abuse prevention and detection are performed as part of the regular functions of SSA staff in district offices, program service centers, and central office, as well as in usual computer routines and matches.

Within SSA, the Office of Assessment (OA) is charged with the overall responsibility for quality assurance and program integrity functions, missions analogous to that of an Inspector General. This includes:

- sample reviews of monthly payments to determine that payments are made to the right person and in the right amount.
- sample reviews of major process transactions to assure that process decisions are made accurately.
- guides to operating people on means for assuring that systems are secure from fraud or unlawful disclosure of records.
- recommendations for correcting weaknesses and eliminating vulnerabilities in SSA's processes and systems.
- guides to assist operating personnel in the detecting and referring of potential fraud cases.
- investigations of potential fraud cases (where SSA employees are involved, cases are referred to the Inspector General in the Department of Health and Human Services).
- audits of administrative and operational processes to determine vulnerability to fraud or abuse.
- Analysis of data gathered during fraud investigative process to pinpoint areas vulnerable to fraud so that appropriate corrective action can be taken.

Resources Devoted to Prevent and Detect Fraud, Waste, and Abuse

Efforts to prevent and detect internal and external fraud, waste, and abuse continue on a daily basis throughout SSA. Benefit claims are reviewed in our district offices and program service centers. Physical and electronic security protects both hardcopy and computer records. Checks and balances are built into our program systems. Because these and other activities are so diverse, it's difficult to put a price tage on the total investment we are making in this area.

Our budget does not provide for more specific activities aimed at assuring the integrity of SSA-administered programs. For example, the fiscal year 1981 budget provided about 2,500 workyears and $70 million for the Office of Assessment. These figures include:

—2,000 workyears for our OASDI and SSI quality assurance systems. These systems provide information on the amounts and causes of incorrect payments and help us formulate appropriate corrective action plans. The bulk of these resources are in the Office of Assessment.

—185 workyears and $5.2 million for program integrity activities. Among other things, the program integrity staff develop anti-fraud policies and procedures and investigate cases of suspected external fraud and abuse. District office staff frequently assist in these investigations.

Continuing disability investigations and SSI redeterminations are two of SSA's major activities that have a fraud deterrence and detection effect. These are performed by staff nationwide.

-- 5,140 work-years and $135 million for SSI redeterminations. The SSI redetermination process verifies continued eligibility and accuracy of payment amounts; district office staff perform the bulk of this work.

-- 1,110 Federal work-years and a total of $83 million for Federal and State involvement in continuing disability investigations. These investigations help insure that disability insurance and SSI disability beneficiaries continue to meet statutory requirements.

In addition to these efforts to combat external fraud, waste, and abuse, resources are also provided for specific efforts aimed at internal or employee fraud. Some examples are:

-- 240 work-years and $5.9 million for internal security in our district offices. Among other things we are piloting ARC procedures which require the use of a personal identification number for field people to gain access to the computer systems. This will allow us to establish an audit trail for all payment transactions.

-- 140 workyears and $3.5 million for fiscal audit and control in our program service centers and central disability operation. Here, staff audit the records of individual benefit accounts against documentary sources to insure the accuracy of our electronic beneficiary rolls.

-- 50 work-years and $1.5 million for systems security officers in headquarters and regional offices to help insure that security is integrated into the management processes of SSA.

Current and Future Activities

SSA is committed to continuous improvement of our fraud prevention and detection systems. We have taken a number of steps to improve systems security. Among the more significant steps are the following:

- -- initiated a Risk Management Program to analyze and identify weaknesses in SSA processes and systems and to develop and implement corrective actions, which will be performed by SSA management and operational staff.
- -- implemented a Systems Security Matrix (software access control for terminals) to insure computer terminals can only access data needed to accomplish a prescribed job.
- -- restricted access to remote terminals to authorized persons only.
- -- provided for automatic locking of terminals to prevent use after the close of business should an employee forget to lock.
- -- improved controls over magnetic tapes and disks at central office.
- -- developed software capability to identify, by way of a Personal Identification Number, the authorizer of payment transactions and the operators of terminals.
- -- developed and distributed a Systems Security Handbook to field offices.
- -- developed a fraud prevention initiative aimed at minimizing the incidence of fraud and abuse by focusing management attention on the correction of vulnerabilities that permitted fraud to occur and go undetected for prolonged periods.
- -- established a Systems Security Officer in every major component in SSA.
- -- implemented a program of random audits of field offices by Systems Security Officers.
- -- designated managers responsible for the security of specific SSA systems.

4. What specific or general impact has the Office of Inspector General had upon SSA's efforts to stem fraud, waste, and abuse?

The Audit Agency, within the Office of Inspector General, provides audits and reviews of (1) programs and activities directly performed by the Social Security Administration—so-called "internal audits"—and (2) programs and activities for which SSA is responsible but which are administred by State agencies—so-called "external audits."

The Audit Agency's internal audit reports and recommendations generally are aimed at improving a particular SSA operation or activity. SSA's policy is to thoroughly review the Audit Agency's internal audit reports and recommendations and implement those that would enhance operations.

The Audit Agency's external audit reports and recommendations are directed to State agencies that help administer SSA programs. A majority of these audits look at State agencies' claims for reimbursements for incurred administrative or program costs. The Audit Agency may also recommend that State agencies make specific procedural improvements. SSA's policy is to thoroughly review these external audit findings and recommendations, make timely determinations as to actions the States must take on them, and follow-up to assure the actions are carried out.

The audits conducted by the Office of the Inspector General have assisted SSA in focusing necessary attention on actions needed to correct vulnerabilities permitting fraud, waste, or abuse in SSA's administrative and operational processes. This is evidenced by the actions taken on recommendations by the Inspector General which have been detailed previously (see Question 1 response).

Through an agreement reached between SSA and the Office of the Inspector General, SSA shares investigative responsibility with the Office of Investigations. This cooperative effort permits both components to concentrate effort and resources in areas that have proven productive in combatting fraud in SSA programs. The OIG involvement in this process brings Departmental level emphasis and priority to fraud prevention and detection.

In addition to the investigation of individual instances of suspected fraud, the Office of Investigations conducts special projects aimed at the detection and deterrence of fraud. Two of these projects which have greatly aided SSA efforts to stem fraud and abuse are:

Project Baltimore

This is an ongoing effort whereby the Office of Investigations, the Social Security Administration, and the Immigration and Naturalization Service have joined forces to investigate the problem of improper social security number (SSN) issuances to individuals, primarily aliens, who misrepresent their identities. This joint approach has resulted in the detection of organized schemes to obtain SSN's for aliens, the prosecution and conviction of the perpetrators and a keener awareness in SSA offices of the need for more aggressive social security number fraud prevention efforts.

Project Spectre

This project focused on the detection of cases where social security benefit payments continued after the beneficiaries' deaths. As a result of this effort SSA has identified approximately 5,000 occurrences of such improper payments. In addition to coordinating the investigative aspects with OIG, SSA is working to recover approximately $30 million erroneously paid to deceased individuals. Moreover, SSA has initiated corrective action to ensure more complete and timely receipt of death notices to prevent future erroneous payments to deceased beneficiaries.

Chairman HEINZ. Well, let me start with Mr. Sermier. As I understand your responsibility, Mr. Sermier, is that you are in the midst of a very important study.

Mr. SERMIER. Yes, sir.

Chairman HEINZ. And you are looking at such things as the IG, his and other people's resources to combat fraud, waste, and abuse, the allocation of resources generally within the Department, the Bureau of Quality Control and the Social Security Administration, the Office of Program Integrity. Is that correct?

Mr. SERMIER. Yes, it is, Mr. Chairman. It's an extremely comprehensive examination of all the resources in the Department that in some way parallel the operations of the Inspector General.

Chairman HEINZ. What is the status of your review?

Mr. SERMIER. We have completed the data-gathering stage. And I expect to forward my recommendations to my superior within the next 2 weeks. And I would assume that within the next month, they will be forwarded to the Secretary and possibly the Secretary will have made a decision. But it will be very, very soon.

Chairman HEINZ. Since you have finished the review, can you tell us how many resources are available within the Department to combat fraud, waste and abuse?

Mr. SERMIER. Well, using the definition that we used to develop the figures in my testimony, it is approximately 10,000 people. That definition includes the people who spend essentially fulltime trying to identify and then point out ways to correct instances of fraud, abuse and waste. As you probably know, Mr. Chairman, waste is the biggest category by far. And waste, in common terms, is just inefficiency. But we can always do almost everything better so waste is the largest category of our losses.

Chairman HEINZ. Waste would be printing checks that are in the wrong amount?

Mr. SERMIER. Yes, Mr. Chairman, assuming all the other information was correct. Waste would include printing checks that are in the wrong amount, using too many people to print the checks, printing the checks too early and thereby preventing the Treasury from accruing interest on the funds, making the Treasury release funds too early, or printing checks too late so that they disadvantage clients. Those are wasteful things, as opposed to fraud or abuse, where someone is trying either with criminal intent or with knowledge, but not in the criminal sense, to take advantage of our programs.

Chairman HEINZ. Now you mentioned that there are about 10,000 people involved fulltime in this effort.

Mr. SERMIER. Yes, sir.

Chairman HEINZ. Where, in the Department, are they? And who do the non-IG components report to?

Mr. SERMIER. Well, they are dispersed within the various components of the Department. We have four major operating divisions. The Public Health Service; and the office of Human Development Services are smaller components. Most of them are within the Social Security Administration and the Health Care Financing Administration. Within Social Security, there are 9,000 people devoted to review, investigation, assessment, and analysis-type activities.

And within the Health Care Financing Administration, about 750, Mr. Chairman.

Chairman **Heinz**. Well, how many does that leave under the control of the IG?

Mr. **Sermier**. Well, the Inspector General has approximately 1,000 people. He testified this morning, I think, that he has 929 on board.

Chairman **Heinz**. So that's about 10 percent of all those resources.

Mr. **Sermier**. Yes, sir.

Chairman **Heinz**. On page 192 of the report that I released this morning, we detailed six specific requests from the IG's office to HCFA for assistance. These requests concerned an investigation in progress. All six requests were denied. To your knowledge of any of this, how often has that kind of thing happened? And from your review maybe, why has it happened?

Mr. **Sermier**. I'm not familiar with that specific instance, Mr. Chairman.

Chairman **Heinz**. From your review, did you come across instances of denials of investigation by the IG?

Mr. **Sermier**. Not without grounds.

Chairman **Heinz**. Not without what?

Mr. **Sermier**. Not without grounds. In other words, where there was a reasonable amount of evidence to sustain that it would not be useful to sustain the investigation.

Chairman **Heinz**. But did you find it quantitatively as opposed as to whether they were justified or not—did you find there were a lot of denials?

Mr. **Sermier**. We did not look for denials per se. I can say this, we did not find any case duplication of effort. That is, we did not find the Inspector General working on precisely the same matter or the same individual case, be it a recipient or an institution as, say, Health Care Financing Administration people were working on. To my knowledge, we did not find instances of denials, but that was not a major aspect of the study. We did cover it, but it was not a major aspect of the study.

Chairman **Heinz**. Well, maybe I can turn to Mr. Kappert about that. Before I do, let me ask you this, Mr. Kappert. One of the major concerns I have got when I survey the plight of the Federal Government's fight against waste, fraud and abuse, is the fragmented nature of our antifraud efforts. How many people are in the Bureau of Quality Control?

Mr. **Kappert**. Approximately 200, then there are other people in 10 regional offices that would support the activities of the Bureau of Quality Control.

Chairman **Heinz**. What would that amount to in total?

Mr. **Kappert**. In total, I think Bob mentioned we had 749 people, depending on what you count. For those activities directly related to the Bureau of Quality Control in the regions, I would have to go back and do a count. But offhand, I would guess around 400 totally. (Actual count 380.)

Chairman **Heinz**. Now what is it that those people do and how is it different from what the Inspector General does?

Mr. **Kappert**. What they do is quite different in terms of the objective of their work. We are not looking any longer at case work, which we have officially turned over to the Inspector General's office. The kinds of work they do would be larger looks, primarily, at the impact of our programs, say, at the provider level, such as we do in the validation reviews. If we come across a fraud situation we do make referrals to the Inspector General. But we are looking for how well, primarily, our programs are operating, looking for opportunities to suggest changes in policies and so forth that will prevent fraud or, even when there is no potential fraudulent situation, where we could better operate to better utilize the dollars we are spending.

In another area, we would be looking at a sample of the cost reports that are processed by intermediaries to determine that the rules for submitting cost reports, which involve as much as $27 billion per year, are being settled correctly.

There are also a number of people who operate quality control systems which sample the transaction by States to determine that they have been accurately processed overall, we are more program-oriented than case-oriented at this point.

Chairman **Heinz**. On page 9 of your statement, you say that you welcome the contributions of the Department's office of the Inspector General. One of the conclusions of the report that I reached this morning is that that doesn't always seem to be the case. On page 193 of that illustrious document that you have in your hand, there is a memorandum from OIG field agent complaining that HCFA had repeatedly refused five times cooperation. The document dated November 10, 1981 concludes that. And that is not very long ago, November 10 of this year. "It's a typical example of relationships with this office, much to the detriment of the Agency's missions. The Audit Director and I will take no further action to attempt to secure services of HCFA Quality Control Division based on their refusal to assist the OIG and the U.S. attorney's office."

Would you care to comment on that? Is there something we could do to see that that kind of thing doesn't happen again?

Mr. **Kappert**. Well, obviously, both letters—they are on page 192 and 193—are new to me. I had not seen them before. What I can say about that is that we have turned from case work—however, with the arrival of the new administration team our Administrator has made it quite clear that the conflicts that did go on several years back are not any longer to be tolerated. And were these things to come to my attention or any of the other senior people, they would be quickly corrected.

Chairman **Heinz**. Well, I have a document here from HCFA called "The Medicare/Medicaid Exchange, Health Care Financing Administration. August-September 1981 issue, Number 5/6." And on page 5 there is a little article about kick-backs, rebates, and it's continued to page 3. And at the very bottom of the article it says, "Persons with knowledge of any suspected kick-back, rebate or bribe arrangements that may effect the medicaid and medicare programs are encouraged to contact Don Nicholson, Director, Office of Program Validation," et cetera, et cetera.

Now why shouldn't those go directly to the Inspector General?

Mr. KAPPERT. Well, I can assure you if, in fact, that particular article or any of our activities turned up criminal activity, it would immediately go to the office of the *Inspector General.*

Chairman HEINZ. Why shouldn't they go directly? Why do they have to go through the supervisors of these people? Someone could draw the conclusion—I would hope wrongly—that the supervisors don't want this word to get out. It would reflect badly on their employees and their department. Now, obviously, you wouldn't share that view.

Mr. KAPPERT. That certainly wasn't the intent.

Chairman HEINZ. But we people can draw that intent even though it may be erroneous.

Mr. KAPPERT. From all the work we do, we know that there is that kind of activity going on. But it does not come forward unless someone tells us about it. It is almost an impossible thing to investigate except, say, in the sense that the FBI did it last year. They went undercover and did the "labscam." It does take professional investigators to be active in that area. This would be just an attempt on our part—that someone might come forward and say, "this is something that needs to be looked into."

Chairman HEINZ. Let me interrupt you at that point. I understand all that. But when they know of a case of a bribe or a kickback or an illegal payment—why shouldn't they go first to the Inspector General and then the Inspector General, if they are tied up, they can refer it to you or the supervisor or someone in HCFA. Why do you want it to come up literally through the administrative channels when it's a crime?

See, we are not talking about somebody who is breaking too many pencils, we are not talking about someone who has overused their paper a lot—this isn't a management issue, it's a crime.

Mr. KAPPERT. I must agree with you that the more appropriate place for those people to go would be to the Inspector General directly. In this case, I would guess at best we are simply augmenting what he might do.

Chairman HEINZ. I don't mean to overreach the analogy, but it's a little bit like some saying, listen, if you know of any loan sharking, don't go to the FBI, just contact your friendly godfather and he will let you know if anything is really wrong.

Mr. KAPPERT. That may come across that way, but that certainly was not the intent.

Chairman HEINZ. I assume you are going to be dedicated to seeing to it that it doesn't come across that way in the future.

Mr. KAPPERT. Certainly.

Mr. SERMIER. Mr. Chairman, we also publicize the existence of the Inspector General's hot line. And all employees are encouraged to use that, and can always go directly to their hot line and get amity with the hot line.

Chairman HEINZ. Well, maybe this publication could have a public service announcement in it on that sometime.

Mr. Sabatini, your figures on improving payment accuracy rates, which you rightly point out are more unintentional errors than outright fraud, indicate that you have been very good at correcting your own mistakes. But what about the actual frauds? What about the acquisition of false social security numbers for illegal aliens, for example? I'm told by people that there are all kinds of people running around this country with illegal social security numbers. What are you doing about that?

Mr. SABATINI. One of the things that we are doing, Mr. Chairman, is changing the method that we use for the issuance of social security cards. We have tightened up drastically on the evidentiary requirements necessary to establish a person's identity in order that they can get a card. And, second, we are improving the issuance process itself so that we can move the card stock out of local field offices to where it can be secure from theft. And we have centralized the issuance of cards directly out of Baltimore.

Chairman HEINZ. Now in the last 5 days, Thursday night and Monday afternoon, when I was up in Pennsylvania on two separate occasions at town meetings that I had, I had people come up to me and they had exactly the same complaint. Which was: "Senator, how is it possible that someone can come into this country at age 65, apparently legally, but the moment they get here having come from someplace else, they immediately start claiming SSI benefits?" Can you explain how that is possible? First of all, is it possible? And second, is it legal?

Mr. SABATINI. Well, SSI benefits are payable to lawfully admitted aliens.

Chairman HEINZ. But how can you have a lawfully admitted alien—maybe I should address this question to the Immigration and Naturalization Service—who comes over here and immediately goes on a program that is essentially a welfare program for the aged, blind, and disabled?

Mr. SABATINI. It's within the statute and if they are lawfully admitted for permanent residence, have lived in the United States for 30 consecutive days, and meet the income and resources test——

Chairman HEINZ. There's no requirement? I know in the case of people under 65, there's a work certification required. Is there no requirement in the other statute that governs such immigration that someone else other than the United States of America would be responsible for those people? Isn't there an affidavit that whoever—those people are coming in here usually because they are someone's parents. And, normally, there is an affidavit, as I recollect—I may be wrong—that says this person isn't going to be a welfare recipient.

Mr. SABATINI. The sponsor of the alien is supposed to provide sufficient support to prevent the alien from becoming a public charge after the alien enters this country.

Chairman HEINZ. Well, apparently that is not happening.

Mr. SABATINI. Right, in some cases.

Chairman HEINZ. What should we do about that? You can blame it on the Immigration and Naturalization Service but it's your problem because you pay for it.

Mr. SABATINI. The problem was greatly reduced for the SSI program with the enactment of a provision by the 96th Congress for considering—that is, deeming—the income and resources of the sponsor to be the income and resources of the alien for up to 3 years after the alien's entry into the country. Preliminary analysis of the effects of the deeming provision—which became effective October 1, 1980—indicates that we are receiving far fewer claims filed by aliens now than we did before October 1980 and are finding eligible only a small number of those who have filed. However, aged, blind, and disabled aliens who had filed for SSI before October 1980 and who are eligible for SSI are not subject to the deeming amendment and thus can continue to receive SSI without regard to their sponsors' income and resources. Also, refugees and others admitted under certain emergency conditions and who, therefore, have not been sponsored, and aliens who become blind or disabled after they enter the United States are not subject to the deeming provision.

The 96th Congress also considered a proposal that would have authorized an alien, a State or the Federal Government to sue the sponsor for support pledged to the alien and authorized States and the Federal Government to sue the sponsor for reimbursement for any public assistance they furnished the alien. This proposal was not enacted.

Chairman HEINZ. Can you recollect why? Do you know what happened to it?

Mr. SABATINI. No, I don't. I don't remember specifically what happened to it.

Chairman HEINZ. In order to move ahead, maybe you or someone on your staff could give us the background of that. Who asked for the legislation? I would be most interested in knowing that, including whether or not it is this administration's policy to seek this legislation.

[The information was subsequently supplied for the record:]

During the late 1970's, the public, the Congress and the Administration became concerned tht the SSI program was being abused by aliens who gained entry into this country with the intention of receiving public assistance. As a condition for entry, immigrants present affidavits by sponsors, usually relatives or friends, that they (the sponsors) would provide support, if necessary, to prevent the immigrants from becoming public charges. However, courts have determined that the affidavits are not legally binding. Further, a sponsored alien who becomes a public charge is subject to possible deportation under immigration law. However, courts also have determined that a person is not a public charge, subject to deportation, unless there is a legal obligation to repay, a demand for repayment, and a failure to repay. Public assistance agencies generally cannot require repayment of benefits for which a person was eligible. Therefore, few persons are deported as public charges. The result was that some sponsored immigrants applied for and began receiving SSI benefits shortly after their arrival.

SSI benefits are not payable to anyone who has been in the United States for less than 30 consecutive days. Under SSI law, needy aged, blind and disabled aliens who have been lawfully present in the United States for 30 days are eligible for SSI benefits if they meet all other program requirements.

In response to the concern that the program was being abused, the prior Administration included in its 1979 welfare reform program submitted to the Congress a proposal to: Make sponsors' agreements of support legally binding for 5 years; authorize legal action against sponsors to obtain reimbursement for public assistance (including that for routine medical care) provided the alien; and provide that aliens who receive unreimbursed public assistance would be regarded as public charges, subject to possible deportation under current immigration law.

The House Committee on Ways and Means adopted, in lieu of the Administration's proposal, a deeming provision which attributed the income and resources of a sponsor to an alien for the length of the support agreement, up to a maximum period of 3 years after the alien's entry. This provision was passed by the House of Representatives in H.R. 4904, the "Social Welfare Reform Amendments of 1979."

The Senate considered the problem of abuse of public assistance by aliens in connection with its consideration of H.R. 3236, the "Social Security Diasbility Amendments of 1980." The Senate adopted provisions for a 3-year residency requirement for entitlement to SSI benefits and for making sponsors' agreements legally binding for a 3-year period. While continuing to express support for its own proposal, the prior Administration supported the Senate bill's provisions as an acceptable alternative. The Administration preferred the Senate's provisions over the House-passed provision in H.R. 4904. Conferees, however, accepted a variation of the House-passed deeming provision that was enacted as a part of the "Social Security Disability Amendments of 1980" and that became effective on October 1, 1980.

This Administration has not sought to have the deeming provision changed because it appears to be having the desired effect of placing the responsibility for support of newly arrived aliens with their sponsors and keeping such aliens out of the SSI program.

Chairman HEINZ. Mr. Sabatini, moving onto another question, I understand most of your case referrals to the Office of the Inspector General consists of employee fraud while you yourselves investigate program fraud. What's the basis of this division of labor? Is it legislative mandate? Is it the instruction of the Secretary? Is it a memorandum of understanding? And whatever it is, how long did it take to clarify and establish this relationship?

Mr. SABATINI. We try to work very closely with the Office of the Inspector General and we operate and work with them under a memorandum of understanding. That was worked out, I think, shortly after the office was established in HHS.

Chairman HEINZ. That was 1977 when the office was established.

Mr. SABATINI. Right.

Chairman HEINZ. How long did it take you to establish that working relationship?

Mr. SABATINI. Approximately one year.

Chairman HEINZ. One year.

Mr. SABATINI. Yes.

Chairman HEINZ. Do you feel that the lines of communication and cooperation are clear and efficient among the various offices charged with combating fraud, waste, and abuse or is further coordination called for?

Mr. SABATINI. Yes. You can always call for some improvement in a working relationship, but I think the one that we have developed with the Inspector General is working quite well.

Chairman HEINZ. Now all of you were asked to track IG recommendations for program changes. Have there been any changes as a result of the IG's recommendations? Mr. Sermier.

Mr. SERMIER. Yes, sir. Of the ones that didn't involve social security and health care financing, there were 18 major recommendations. And all but two have been implemented. One of them was not implemented. We did not agree with the amount of resources that the Inspector General thought we should devote to onsite visits to recipients of funds who don't receive a great amount of funds.

The second one that has not been implemented, we agree with the Inspector General, but we are prevented really from defining consultant services concisely. We have, unfortunately, an unclear definition of what constitutes consultant service. But there's a difference between the Office of Management and Budget and our Senate Appropriation Subcommittee.

Chairman HEINZ. What about HCFA?

Mr. KAPPERT. We believe we have been very responsive to the IG's recommendations, certainly in the financial area. The Secretary had, in fact, demanded that all pending audits on the financial side open more than 6 months be closed by the end of September. And HCFA did, in fact, do that.

You asked in your request about three particular, very difficult program areas where the Inspector General had made recommendations. These are recalcitrant areas but we are working very hard on them. In fact, the Congress has also been very much involved. For one of the areas that I referred to, the management of the personal care services under title XIX you enacted in a recent reconciliation bill a waiver provision with respect to that activity.

The other two areas that have been most difficult to deal with about which we also have recommendations from the Congress are the requirements for reimbursing teaching physicians and for reimbursing other types of hospital-based physicians. It's a very complex and complicated provision of the law. We expect by the turn of the year to have major recommendations in both areas. That work will come out of suggestions from the Inspector General's office, the Congress, and our own work as well.

Chairman HEINZ. That's two out of three. Is there a third?

Mr. KAPPERT. The third had to do with the—here were two in the physician reimbursement area. One on teaching physicians which is a little bit different problem than the basic one.

Chairman HEINZ. How many recommendations—IG type recommendations—altogether?

Mr. KAPPERT. I don't have a total number.

Chairman HEINZ. To speed things up, maybe you could submit the same kind of statistical information that Mr. Sabatini was going to provide.

[The information was subsequently supplied for the record:]

Only three I.G. audits of HCFA activities in fiscal year 1980 were related solely to program management subjects. Previous testimony covered those three audits. In 410 additional audits, there were program management findings in addition to the financial findings. HCFA has resolved all financial issues in all audits.

In addition, all management findings have been resolved in 373 of the 410 audits. In the remaining 37 audits, the management findings are being reveiwed and tracked to final resolution.

Mr. SABATINI. In the material text of my testimony, you will see that the recommendations that you asked about are there.

Chairman HEINZ. All right. I have got one last question which is this: Were you here for our first witness this morning, a Dr. Kones?

Mr. SERMIER. Yes; I was.

Chairman HEINZ. Now here you are, very able gentlemen working very hard to combat waste, fraud, and abuse. How is it possible that a convicted fellow, who has been convicted, and wants to get caught and convicted, manages over a 6-year period not to get caught? And in the process bills and steals over $2 million for totally fraudulent claims using devices that, according to his testimony, should have in 16 different ways and various ways attracted the attention of someone somewhere in the great bureaucracy that we call HHS. How is that possible, and what is there that any of you are doing about it that is going to make that system less susceptible to people not only who want to steal but who don't want to get caught, let alone those that do want to get caught?

Mr. KAPPERT. I guess it is most appropriate for me to try that one. First of all, what he got away with in 1974 I would have to agree was possible in 1974. The sophistication in terms of automated systems in detecting duplicate billing and claims for unnecessary services, claims not rendered and so forth——

Chairman HEINZ. He got caught the first time in 1974.

Mr. KAPPERT. But we did, in fact, pick him up when he got into what he called his second mode. I think it was——

Chairman HEINZ. $2 million later.

Mr. KAPPERT. Well, I think it was quite self-serving on his part to say that all he did was so unsophisticated and so forth. I think the man was, in fact, very bright and he did use devices that deceived the system. There were circumstances that he did not necessarily testify about that also occurred at that time. When he was first picked up in that particular period when he was under investigation, he probably didn't know he was under investigation. We have a provision where we ask the U.S. attorney that while you are investigating, what do you want us to do. He says, "Don't tip him off. Keep paying him." So there we are in this situation where in order for him to build the case, we have to continue to pay even knowingly, claims that may or may not be fraudulent or certainly at least excessive.

Even if it was not as well done in 1978 and 1979, I think things are better now. We have worked very diligently with States and contractors to improve claims processing capability. I don't think that Dr. Kones' case could happen again anywhere in the United States.

Chairman HEINZ. Maybe not. I am going to have to ask a question verbally for the record. Let me state the question and then I am going to have to adjourn the hearing. Someone can indicate who is going to answer it for the record.

Let's think back to the testimony of Mr. Shuttleworth. Now what I found fascinating about his testimony that although there is a State effort to catch people—in this case, the Medi-Cal program, their version of the medicaid program—according to his testimony, there is really no effort by anybody in HHS to make sure that States have an effective program to catch people. And maybe that's true; maybe that's false, but that's his testimony. And I would like to know who is going to answer it for the record.

Mr. SERMIER. I will answer it, Mr. Chairman.

Chairman HEINZ. Mr. Sermier, I thank you very much. I regret that I have to go during this hearing at this time, but such is the case. I thank you all for being here.

[Whereupon, at 3:25 p.m., the hearing was adjourned.]

[The information follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES
Office of the Secretary
Washington, D.C. 20201

DEC 28 1981

The Honorable John Heinz
Chairman
Senate Special Committee on Aging
United States Senate
Washington, D. C. 20510

Dear Mr. Chairman:

Thank you again for permitting me to appear before you on December 9, 1981, to discuss the Department of Health and Human Services' (HHS) efforts to control fraud, abuse and waste. At the conclusion of the hearing, you asked a question regarding the earlier testimony on California's Medicaid fraud investigations efforts by Mr. Charles Shuttleworth of the Investigation Branch in California's Department of Health Services. Your question concerned whether HHS ensured that States have effective programs to identify Medicaid fraud activities.

Attached, for the record, is the response to your question. I hope this information is helpful in clarifying the testimony on the Department's efforts to ensure that States have effective medicaid fraud investigation programs.

I will provide the response to the questions in your letter of December 18, 1981, by January 15, 1982 as requested.

Sincerely yours,

Robert F. Sermier
Robert F. Sermier
Deputy Assistant Secretary for
Management Analysis and Systems

Attachment

Question: How does HHS ensure that States have effective programs to identify Medicaid fraud activities?

Answer: States have two potential mechanisms to identify Medicaid fraud and abuse. Each State Medicaid Agency has a surveillance and utilization review unit which is responsible for identification of potential fraud and abuse situations. State Medicaid Agencies with certified Medicaid Management Informations Systems (MMIS) must have a surveillance and utilization review component which performs routine screening of Medicaid claims to detect instances of provider fraud. There are 36 States with a certified MMIS. A State may also have a State Medicaid Fraud Control Unit (SMFCU) which is responsible for investigation of Medicaid Fraud cases and prosecuting violations of all applicable State laws pertaining to Medicaid health provider fraud. SMFCUs are separate from the State Medicaid Agency. Currently, 29 States have certified SMFCUs. In those States without an SMFCU, the State Medicaid Agency refers health provider fraud investigations to the State Attorney General's office, local district attorneys or other law enforcement agencies.

The Department has several ongoing efforts to ensure that States have effective programs to identify Medicaid fraud activities. One of the methods used to oversee the fraud investigation efforts of the States is an Annual State Evaluation Review of all State Medicaid Agencies. The Department's Health Care Financing Administration (HCFA) performs these comprehensive assessments which measure the overall operational performance of the State Medicaid Agency. A major section of the evaluation is specifically related to the area of program integrity and involves a review of the State Agency's efforts to identify fraud and abuse activities. Some of the other general areas covered by this evaluation are administration and management, claims processing, eligibility determination, financial management, institutional and non-institutional reimbursement, provider enrollment relations, service delivery, and third-party liability identification. The reviews HCFA conducts in these latter areas indirectly aid in reducing fraud, abuse and waste because virtually all the procedures we require States to follow are in some way related to avoiding inefficiency and assuring that only eligible recipients receive benefits.

The program integrity functions are usually performed by the surveillance and utilization review unit of the State Medicaid Agency. In the California State Medicaid Agency, this unit includes the Investigations Branch headed by Mr. Shuttleworth. In conducting the program integrity portion of the evaluation, HCFA reviews the State agency's efforts to detect potential fraud and abuse cases and the referral of these cases for further investigation or prosecution. The criteria HCFA uses for evaluating program integrity activities includes review of the written procedures established for development of potential fraud cases, the number of cases reviewed, and the number of cases referred for investigation to the SMFCU or other law enforcement agencies (in those States without a certified SMFCU). HCFA also reviews the administrative actions taken by the State Medicaid Agency in those cases where fraudulent activity is identified. I have attached a copy of the program integrity section of the Annual State Evaluation Review for fiscal year 1982 to provide you with the specific criteria used during the evaluation (Enclosure 1).

Another process used by HHS to monitor States' efforts to identify Medicaid fraud and abuse is through the annual review of the performance of SMFCUs by the Department's Office of Inspector General (OIG). Each SMFCU is required to meet specific requirements in order to obtain its annual certification by HHS. The OIG performs an audit each year of the SMFCU's activities as part of the certification process. The purpose of this review is to make sure that units are investigating cases of potential fraud and are able to prosecute (or effectively refer for prosecution) these cases on on a State-wide basis. In reviewing the overall performance of an SMFCU, the OIG examines the the qualifications of the units' staff, the adequacy of procedures used and results obtained (both qualitatively and quantitatively), including the number of cases initiated and completed, the number of recovery actions initiated, and the amount of overpayments collected. I have also attached a copy of the recertification manual used by OIG during their review of SMFCUs (Enclosure 2). The manual contains the guidelines for the review, the legislation authorizing the program, and the SMFCU regulations. Also attached is an example of an actual survey which is included with the recertification manual in the form in which it appears (i.e., with identifying items deleted).

Both types of reviews described above include sections which focus on the coordination activities between the State Medicaid Agency and the SMFCU. HCFA and the OIG have encouraged and will continue to encourage the personnel of the State Medicaid Agency and the SMFCU investigators to work closely with each other, but will increase their activity in this area. As a first step, the Department will formally survey the States to identify problems that exist between medicaid program administration and fraud investigation activities. The initial questionnaire (Enclosure 3) asks for information on workload, staffing levels, and budgets for both the State Medicaid Agency's Investigation Unit and the SMFCU, and the State's opinion on how to improve coordination. The questionnaire has received the approval of the Office of Management and Budget, as required by the Paperwork Reduction Act of 1980. The Department will send the questionnaires to the States within the next month. The information provided by the States should help HCFA and OIG to identify and then correct problems that may exist between State Medicaid Agencies and SMFCUs.

Enclosures

PROGRAM INTEGRITY:

The Program Integrity Section of the State Assessment Guide consists of eight criteria for evaluation. Following these criteria is one supplemental area which you may evaluate if you wish. The supplemental area will not be appropriate to evaluate in all States. Certain elements within this section will not be scored for MMIS States (A-2, 3; D-1) because they will be reviewed and scored under the Systems Performance Review (SPR). The eight criteria require the following samples/documentation for evaluation.

Criterion/Topic	Element	Sample/Documentation
A-Detection	1	Documented procedures
	2	Documented provider reviews, exception reports.
	3	Documented recipient reviews, exception reports.
	4	Special sample of settled audits.
	5	Interviews, documentation of educational contacts.

B-Recipient Responses	1	Regular sample of discrepant recipient responses and the resulting cases.
C-Development	1	Special sample of closed integrity reviews
	2	Special sample of closed full scale abuse cases
D-Administrative Mechanisms	1	Documentation of administrative actions.
	2	Special sample of closed full-scale abuse cases
	3	Regular sample of providers from correspondence requesting prepayment review.
E-Reporting	1	Review of HCFA Form 52 and State logs.
	2	Special sample of closed full scale abuse cases.

F-Fraud Units	1	Check State logs
	2	Check State logs. Regular sample of cases referred from unit for administrative action
G-Investigative Units	1	Check State logs
	2	Check State logs. Regular sample of cases referred from unit for administrative action.
H-Penalties	1	Documentation of notification of penalties.

Program Requirement: The State must prevent and control fraud and abuse in the Medicaid program.

NOTE: Reviewers will monitor the States' activities in the detection and referral of potential fraud and abuse cases. Reviewers will also monitor abuse case development but will not monitor the development of potential fraud cases under this section.

Criterion A: The State agency must have procedures and methods for the detection and review of fraud and abuse situations.

Element 1 - The State should have written procedures regarding the identification, development and referral of potential fraud and abuse situations. (42 CFR 455.13)

Method of Evaluation

The reviewer should verify that written procedures exist to identify, develop and refer cases of potential fraud and abuse. At a minimum there should be instructions for:

1. Claims processing personnel regarding identification and referral of potential fraud and abuse. For example claims processing personnel should be instructed to look for an indication that a claim was submitted for services not rendered, a provider's bill appears to have been altered or that

double billing may be deliberate. Instructions should also be included to distinguish the potential fraud and abuse case from an obvious clerical error or an internal bill processing error.

2. Audit staff regarding identification and referral of potential fraud and abuse. For example, auditors should be instructed to look for an indication that ancillary services were billed but not rendered, overcharging for ancillary services, personnel on payroll (especially relative of the owner/administrator) but not rendering services, non-arm's length transactions to increase depreciation, and repeated audit adjustments.
3. Case development staff regarding the development and referral of potential fraud and abuse. For example, staff should be instructed to assure that clerical error was not involved, to verify the complaint with the recipient when appropriate, how to conduct recipient interviews, and steps to follow when there is a question of medical necessity (referral for medical review) or a question of fraud (referral to an investigative unit).
4. Correspondence unit (where appropriate) regarding identification and referral of complaints of potential fraud or abuse.

APL=State has written procedures to identify, develop and refer potential fraud and abuse cases. Use non-numeric scoring. The weight is 5.

Element 2 - The State must periodically review an established minimum of active providers identified through the exception process. (42 CFR 455.13) (NOTE: Do not score for MMIS States as this will be scored under the SPR).

Method of Evaluation

Active providers are those who have provided at least one (1) adjudicated Medicaid service during the review period, unless the State's definition is based on a greater number of services. The definitions of types of services, which appear in Appendix A of the instructions to State agencies for completion of the HCFA-120 report, are to be used for determining the groupings of provider types.

The State must review each quarter at least .005 (.5%) (but not less than ten (10)) of the total body of active noninstitutional providers of each of the following service type groupings:

(1) Physicians' Services and Clinic Services
(Definitions 8 and 12)
(2) Prescribed Drugs (Definition 16)
(3) All others.

The State must review annually at least .005 (.5%) (but not less than ten (10) of the active institutional providers of each type of service indicated in the following groupings:

(1) Inpatient Hospital Services (Definition 1)
(2) Long Term Care Services (Definitions 2 through 7)

Both the non-institutional and the institutional providers to be reviewed are to be selected from those identified through the ongoing exception process. Review State logs, etc., to assure that minimum review levels were met. Document that exceptions were analyzed and/or reviewed on the basis of statistical factors, medical factors or both, as appropriate. Examples of appropriate documentation are: 1) a case file (or card file) maintained by the State for each reviewed provider and containing detailed information on the analysis/review; and 2) the reports produced via the State's automated monitoring/reporting system.

APL=State periodically reviews an established minimum of active providers identified through the exception process. Use non-numeric scoring. The weight is 5.

Element 3 - The State must periodically review an established minimum of active recipients identified through the exception process. (42 CFR 455.13) (NOTE: Do not score for MMIS States as this will be scored under the SPR).

Method of Evaluation

By active we mean the recipient incurred at least one (1) adjudicated service during the review period, unless the State's definition is based on a higher number of incurred services.

The State must review each quarter at least .0001 (.01%) of the total body of active recipients (but not less than 25). The recipients to be reviewed are to be selected from those identified through the ongoing exception process. Review State logs, etc., to assure that minimum review levels were met. Document that exceptions were analyzed and/or reviewed based on statistical factors, medical factors, or both as appropriate. Examples of appropriate documentation are: 1) a case file (or card file) maintained by the State for each reviewed recipient containing detailed documentation; and 2) the reports produced via a State's automated monitoring/reporting system.

APL=State periodically reviews an established minimum of active recipients identified through the exception process. Use non-numeric scoring. The weight is 3.

Element 4 - The State should have an audit capability (for both desk reviews and onsite audits) that identifies and refers cases of potential fraud and abuse.

Method of Evaluation

Review a special sample of audits settled during the review period.

APL=90% of the cases reviewed reveal that all situations of potential fraud or abuse were referred to the appropriate State component within 30 calendar days (from the date of identification of the potential fraud or abuse). If the reviewer finds a situation of potential fraud or abuse that was not referred, it is to be counted as an error. The weight is 3.

Element 5 - The State should have educational contacts with other components which might be expected to detect and refer cases of potential fraud or abuse.

Method of Evaluation

The reviewer should ascertain through discussion with management personnel and through verification of documentation that the State makes an effort to educate other State and local components (e.g., county welfare offices) and the public in the recognition of a fraudulent or abusive situation and how to refer this situation to the State.

APL=There is documentation of the State's effort to educate these entities on the identification and referral of fraud and abuse cases. Use non-numeric scoring. The weight is 1.

CRITERION B: The State must have a method for developing recipient responses to verification notices.

Element 1 - The State should follow up on the results of the EOB verification process in which services were questioned by recipients. (42 CFR 455.13 and 455.20).

Method of Evaluation

Review a regular sample of discrepant recipient responses received during the review period. If the universe is 25 or less use the small universe scoring chart.

APL=90 percent of the discrepant responses were developed and/or referred for development of potential fraud or corrective action in accordance with State guidelines or agreements. The weight is 3.

CRITERION C: The State must have a method for developing cases of potential abuse.

Element 1 - The State must properly develop integrity reviews.

Method of Evaluation

Review a special sample of integrity reviews closed during the review period.

APL=90 percent of the cases indicate proper development with one or more of the following actions documented in the file: review of profile reports; requests of medical records for inhouse review; contacts with recipients, employees or past employees; onsite review of provider; referral for fraud investigation; recoupment where appropriate; timeliness (the reviewer should verify that case actions take place without undue periods of case inactivity). The weight is 3.

Element 2 - The State must properly develop full-scale abuse cases.

Method of Evaluation

Review a special sample of full-scale abuse cases closed during the review period.

APL=90 percent of the cases indicate proper development with documentation in file of one or more of the actions listed in Element 1 (above) and/or any of the following: medical review, peer review, contact with the provider. The weight is 3.

CRITERION D: The State must have administrative mechanisms in place to take actions against those found to be abusing the Medicaid program.

Element 1 - The State must establish procedures for appropriate follow-up action on any abusive situations discovered. (42 CFR 455.16) (Do not score for MMIS States as this will be scored under the SPR).

Method of Evaluation

Review the State procedures to assure that appropriate administrative mechanisms are in place. Secure documentation or data to confirm these mechanisms are being used to follow up and remedy abusive situations discovered.

The following mechanisms must be available:

(1) Recoupment.

(2) Prepayment Claims Review.

(3) Peer Review.

(4) Mechanisms of referral for fraud, abuse and licensure violations.

(5) On-going monitoring

(6) Lock-in where permitted by State policy.

(7) Suspensions and Terminations.

APL=Administrative mechanisms are in place and being used to follow up and remedy abusive situations. Use non-numeric scoring; the weight is 3.

Element 2 - The State must take actions befitting the analysis of individual cases. (42 CFR 455.16)

Method of Evaluation

In a non-MMIS State review a special sample of closed full-scale abuse cases.

In an MMIS State, review a special sample of closed full-scale abuse cases which originated from a source other than SURs.
APL=In 95 percent of the cases reviewed, documentation exists supporting the actions or lack of actions. Appropriate actions include the available administrative mechanisms identified in Element 1, above. The weight is 5.

Element 3 - The prepayment review system should screen the services of those providers determined as a result of postpayment analysis to require prospective monitoring through the prepayment system.

Method of Evaluation

Select a regular sample of providers from correspondence or other documentation substantiating requests by the post-payment operation that the prepayment operation place certain providers on prepayment review.
APL=90 percent of the sample of providers identified from the correspondence or other documentation were put on prepayment

review. If there were no requests to put a provider on prepayment review, count this element as not reviewed but assure that the problem is reflected in the score for Criterion D-1 above. The weight is 3.

CRITERION E: Abuse information must be reported to the HCFA Regional Office correctly and on a timely basis.

Element 1 - The State must report the required information on the HCFA Form 52 on a timely basis and in accordance with workload instructions. (42 CFR 455.17)

Method of Evaluation

The reviewer is to ascertain that the required information is reported to HCFA on the Form 52 within 15 calendar days after the end of the quarter. Timeliness is determined by receipt of the Form 52, accuracy can be determined by reviewing State logs and/or control system and integrity review case files.

APL=Abuse information is reported on the Form 52 correctly and timely. Use non-numeric scoring. The weight is 3.

Element 2 - The State must report information required by the HCFA Form 51 on a timely basis. (42 CFR 455.17)

Method of Evaluation

Use a special sample of closed full scale abuse cases. Determine that the required information (i.e., update information on overpayments identified, etc.) was reported to HCFA within 30 calendar days after the identification of a case action.

APL=95 percent of cases reviewed have case actions reported within 30 calendar days of identification. The weight is 3.

CRITERION F: The State agency must cooperate with the State Medicaid Fraud Control Unit where it exists pursuant to the requirements of 42 CFR 455.300.

Element 1 - The State must comply with the unit's request for information and records. (42 CFR 455.21).

Method of Evaluation

Select a regular sample from the State agency records listing the fraud unit's request for information.

APL=The State has provided the requested information within 45 days to 80 percent of the unit's requests for records or information. The weight is 3.

Element 2- On referral from the unit, the State must initiate administrative or judicial action to recover improper payments. (42 CFR 455.21).

Method of Evaluation

Review State agency records and select a regular sample of cases referred from the unit to the State.

APL = In 95 percent of the cases the State has initiated appropriate administrative actions within 60 days from the date of referral. The weight is 5.

CRITERION G: The State must cooperate with the fraud investigative unit. (This applies to States without certified Medicaid Fraud Control Units).

Element 1 - The State must comply with the unit's request for information and records.

Method of Evaluation

Select a regular sample from the State agency records listing the fraud unit's request for information.

APL=The State has provided the requested information within 45 days to 80 percent of the unit's requests for records or information. The weight is 3.

Element 2 - On referral from the unit, the State must initiate administrative or judicial action to recover improper payments. (42 CFR 455.16)

Method of Evaluation

Review State agency records and select a regular sample of cases referred from the unit to the State.

APL=In 95 percent of the cases the State has initiated appropriate administrative actions within 60 days from the date of referral. The weight is 5.

CRITERION H: Providers and recipients must be informed of penalties for fraud.

ELEMENT 1 -The State agency must notify providers and recipients of the provisions of section 1909 of the Social Security Act which provide Federal penalties for fraudulent acts and false reporting. (42 CFR 455.22)

Method of Evaluation

Review State procedures and documentation to ensure that providers and recipients are notified of penalties. Note that the statement provided on the claims form and/or check as required by 42 CFR 455.18 and 455.19 are not sufficient to meet this requirement.

APL=Providers and recipients are notified of penalties. Use non-numeric scoring; the weight is 3.

SUPPLEMENTAL REVIEW

SUPPLEMENTARY CRITERION A:

The State should have an audit capability that identifies and refers cases of potential fraud and abuse.

Element 1 - Where the State has an audit unit with responsibility for conducting financial audits of non-institutional providers (i.e., pharmacies and dentists),all cases of potential fraud and abuse and should be identified and referred to the appropriate State component.

Method of Evaluation

Review a special sample of non-institutional audits settled during the review period.

APL=90 percent of the cases reviewed reveal that all situations of potential fraud or abuse were referred to the appropriate State component within 30 calendar days (from the date of identification of the potential fraud or abuse.) If the reviewer finds a situation of potential fraud or abuse that was not referred, it is to be counted as an error. The weight is 3.

ENCLOSURE 2

STATE MEDICAID FRAUD CONTROL UNIT

Recertification Manual

Department of Health and Human Services
Office of the Inspector General
Division of State Fraud Control

1. INTRODUCTION

1.1 PURPOSE

This manual is to describe the process and responsibilities whereby the Department of Health and Human Services recertifies State Medicaid Fraud Control Units (hereinafter called "units") as eligible for 90 percent Federal cost sharing. Congress mandated that such units must be recertified annually by the Secretary and this authority has been delegated to the Inspector General; since the functions of the units (criminal investigations, investigative audits, and criminal prosecutions of cases of alleged Medicaid provider fraud) are most closely related to the investigative and audit functions of the Office of the Inspector General (OIG). Prior to April 15, 1979, the responsibility had been delegated to the Health Care Financing Administration (HCFA), Office of Program Integrity (now renamed as Office of Program Validation). Since April 15, 1979, the Division of State Fraud Control, OIG (which reports directly to the Deputy Inspector General) has had responsibility for all areas of the administration of the grants to these units; as well as for other State efforts regarding the investigation and prosecution of instances of program fraud.

1.2 BACKGROUND

The Federal/State Medicaid program is the result of legislation enacted in 1965 which provided for State-administered and Federally-monitored financing of medical service for needy families. No specific provision was included for investigative or prosecutive entities in the original legislation. By 1977, Medicaid had grown to a $19 billion program (in Federal/State dollars) and the Inspector General estimated that Medicaid fraud and abuse was costing at least $653 million annually. These losses were threatening the integrity of Medicaid, and enactment of the fraud control unit legislation was one of the major steps by the Congress to bring such losses under control.

Medicaid fraud is costing the American taxpayer millions of dollars annually, dollars which could be spent on quality medical care. Even more dangerously, countless thousands of Medicaid beneficiaries are being exposed to care and treatment not merely unnecessary, but in too many cases, injurious to health and well being. No longer can Medicaid fraud be considered exclusively "white collar" crime. It is becoming demonstrably clear that fraudulent and abusive practices of certain Medicaid providers are undermining the Congressional and program goals of providing quality medical care to society's poorest constituencies at a reasonable and affordable cost. Further, it is becoming evident that the lessons being learned apply not only to Medicaid but also to our total health care delivery system and any future national insurance program.

U.S. Public Law 95-142, which became effective October 25, 1977, authorized State Medicaid Fraud Control Units in every Medicaid jurisdiction and provided for 90 percent financing by the Federal Government for establishment and operation of the units during a nearly three-year period ending September 30, 1980. The law requires that the applicant States meet several requirements in order to obtain annual certification by the Department of Health and Human Services (formerly Department of Health, Education and Welfare). Most notable of these are the requirements that the units have not only the capability to investigate potential Medicaid fraud, but also the ability to prosecute cases on a state-wide basis, or have assured access to such prosecutive ability.

1.3 SUMMARY OF RECERTIFICATION PROCESS

The recertification process relys on a review of each major function of the unit by a professional in that function: an investigator (from the Office of Investigations of OIG) reviews the investigative function; an auditor (from the Audit Agency of OIG) reviews the audit function of the unit and the fiscal integrity of the grant; and an attorney (from the Division of State Fraud Control or the Office of General Counsel) reviews the prosecutive function.

Ordinarily, the recertification staff will be assigned eight to ten weeks prior to the expiration of the unit's certification, documentation distributed for review, and an on-site visit scheduled for four to six weeks prior to the expiration of certification. The recertification review staff will meet prior to meeting with the unit; and entrance and exit conferences will be held. Draft reports are prepared by the review staff, a composite draft report is issued by the Division of State Fraud Control (DSFC), and; after considering comments, a final report issued to the State. Units may be recertified, recertified conditionally and given time to make improvements, or decertified.

2. RECERTIFICATION REVIEW STAFF RESPONSIBILITIES

Prior to the on-site evaluation of Section 17 Medicaid Fraud Control Units, this division will notify the State of the requirement to submit an application for recertification, report of expenditures, proposed budget, and an annual report. Upon receipt of the above documents, the division staff will work with the State unit to resolve any or all issues or problems and will then provide copies of the documents to the review staff. This division will also establish the date for the on-site review and coordinate necessary actions with the Audit Agency and the Office of Investigations to assign personnel to the review staff.

In reviewing assignments, members may notice that there is some overlap in coverage. They should compare notes with other review staff on these areas so that there is no major duplication of effort, however on cross-cutting issues or problems, the different perspectives of the different professionals on the review staff may be utilized. Also, for an evaluation of the team approach the different members will review the relationships with different unit personnel to insure that an accurate evaluation is made.

2.1 REVIEW SUPERVISOR'S RESPONSIBILITIES

Review recertification application and insure compliance with all provisions of 45 CFR 455.300, paragraphs (h)(3) and (i); and determine if any of the information raises questions as to compliance with any other regulation. Contact review staff members and verify that they received copies of: state aditure reports, prior year recertification report, and any other necessary documentation. Contact Special Agent in Charge (SAC), Office of Investigations for the region which includes the unit, inform him/her of recertification of plans, and ask for an informal appraisal of the unit and any problems the SAC may think worth pursuing (any such communication should be held in confidence from the unit). Notify the review staff of all open issues which the division staff has identified as a result of its review and analysis of the State's submissions or which has otherwise come to the division's attention.

Coordinate administrative aspects of the scheduled time of arrival, date, location, etc.

Prior to arrival at State unit, brief all team members on purpose of and procedures to be used during and after onsite review.

Review State submissions for recertification and the recertification review guide with review staff

The review supervisor should conduct an entrance conference with unit management upon arrival at the unit. This entrance conference should generally cover the points in the Recertification Field Guide, Attachment A.

Prior to the on-site visit, the review supervisor should determine (in consultation with the unit director) whether to attempt to arrange a meeting with the Medicaid agency and whether this should include unit representation. If a meeting is held, it should not be scheduled for too early in the on-site visit since a careful review with the unit of the relationship must be made before such a meeting. Appendix 3 of the Recertification Field Guide gives an outline of possible points for such a meeting.

The review supervisor should confirm all assignments and insure that all areas, A through D of the Field Guide are assigned to specific members of the review staff. He/she should lead entrance and exit conference--first with review staff and then with the unit chief.

The exit conference should be informal and should be started by the review supervisor who should give a short overview of results--not neglecting the positive findings, and, if appropriate, state up front that the unit will be recommended for recertification. Then each member of the review staff should give a summary of his/her findings (again, not neglecting positive findings!); and especially his/her recommendations. The unit should have the opportunity to discuss all adverse findings and recommendations. Finally, the unit should be asked if there are any findings or recommendations which they would like included in the report--

these should be carefully considered, but included only if convinced of accuracy and reasonableness.

The review supervisor should also follow-up as necessary with review staff to insure submission of their reports in compliance with established due date. Upon receipt of all elements of report of on-site review, he should draft a consolidated review report for submission to the Director, Division of State Fraud Control (see page 14 for outline). Based on all available information and judgments of the team and any others, the division director will make a recommendation for recertification, conditional recertification, or non-recertification, and make recommendations on any budgetary matters.

2.2 AUDITOR'S RESPONSIBILITIES

The auditor's principal responsibilities fall into two areas: (1) the review of the unit's audit capabilities (qualifications of unit auditors, audit techniques, etc.) to perform investigative audits of providers suspected of Medicaid fraud or patient trust fund misappropriation; and (2) a cursory review of the fiscal integrity of the grant of the unit. The first is of considerable importance and requires a well-qualified auditor knowledgeable about audit techniques, processes, and standards. The second is of lesser concern and may easily be abbreviated in the professional judgment of the auditor unless there is reason to suspect major errors or even fraud.

Upon receipt (and prior to meeting with other review staff) the auditor should review expenditure reports, annual report and application for recertification. These materials may contain answers to questions assigned for review.

At briefing meeting with other review staff, prior to arrival at State unit, advise them of any/all issues which have arisen out of the auditor's desk review.

Utilize the Recertification Field Guide and address the issues (within the auditors professional judgment of what is necessary in this particular State) covered by the "Audit Capability and Fiscal Integrity" section of the Guide. Also, develop any other areas which are relevant and important to fiscal integrity and audit aspects of the unit's operation. During interviews with unit staff and reviews of documentation, the auditor should keep in mind any potential problems which are the principal responsibility of another team member and make appropriate adjustments in review plans. He should also make the appropriate review staff member (especially the review supervisor) aware of all relevant information, observations, or impressions. He should inform the review supervisor of all significant findings and recommendations, and participate in the exit conference with the unit director. His report to the review supervisor (in the form of a memorandum with appropriate attachments from the individual auditor to the Division Director), addressing all audit and fiscal integrity areas listed in the Recertification Field Guide and other pertinent findings, observations, and recommendations should be submitted in adequate time to meet the agreed upon "due date"(generally within two weeks of exit conference unless further documentation, etc. must be acquired from the State).

Review proposed budget and its rationale for any inconsistencies between it and observed historical data or any other observations which should be made known to the Division of State Fraud Control. Make such information known informally or in a memorandum to the review supervisor.

2.3 INVESTIGATOR'S RESPONSIBILITIES

Upon receipt (and prior to meeting with other review staff) the investigator should review the annual report and application for recertification.

At briefing meeting with other review staff, prior to arrival at State unit, advise them of all issues which have arisen out of the investigator's desk review of the material.

Utilizing the Recertification Field Guide, address (within the investigator's professional judgment of what is necessary or appropriate in the particular State) all areas covered by the "Investigation" section of the guide. Also, inputs can be possibly withheld under the FOIA. Similarly, the reports should be professional and objectively based upon facts and observations.

Report Format

We would prefer the format to be:

Area of Review--Give the heading from the Field Guide table of contents, or when appropriate to further breakdown the contents of the report (i.e. for a major deficiency in a narrow part of one of the major topics given in that guide), give an appropriate title describing the area reviewed.

Examples:

B.5. INVESTIGATIVE TECHNIQUES AND PROCESSES

C.2. TRAINING OF UNIT AUDITORS

Scope--Describe any directly relevant review steps that were taken which form the basis for the findings and recommendations given (this item may be left out if the scope seems obvious or there seems no likelihood that anyone would question our basis for the findings).

Findings--Describe any problems, areas of concern, or noteworthy good features of the unit and enough background for a reasonable understanding.

Recommendations: For the final report, we will only include recommendations to the unit or its parent organization, so such recommendations should be made first; if the author wishes to make additional recommendations to other Federal or State agencies (e.g. the Medicaid Agency or HCFA), separate them and indicate clearly to whom the recommendation is addressed. General recommendations are encouraged and may be made in an introductory part of the memo.

Examples of sections of reports are shown in Attachment C.

3. REPORTS AND FOLLOW-UP

3.1 FINAL REPORTS AND RECOMMENDATIONS FOLLOW-UP

The Division of State Fraud Control is responsible for the compilation of the actual report to the State--both from the inputs of the investigator and auditor and from this division's other sources of information. Therefore, the auditor and the investigator should expect that, although most of their inputs will become a part of the report without change; other parts may be edited for style or tone, revised to conform to division policies, or deleted. This should not be considered a reflection of the division's confidence in the work or judgment of the auditor or the investigator and we encourage a frank report (though use discretion in what is written versus oral communication with the Freedom of Information Act).

Normally, the review supervisor will be responsible for preparing the first draft of the report, sharing this with the team members, making whatever decisions are necessary, and sending a further draft to the unit for State comments. The State should provide comments within two weeks and a final report should be prepared and sent out to the State with a request that a response to the recommendations be made in two or more weeks. The review supervisor should insure that there is adequate response and follow-up on all recommendations.

E. REPORT OUTLINE

Background - Give relevant background, history, organizational location, staff size, and facilities.

Liaison Activities - Describe major liaison activities; especially with the Medicaid agency for case referrals and with prosecutors' offices if the unit refers cases for prosecution. Describe any problems in liaison (e.g. Federal or State law enforcement agencies, other prosecution offices, etc.)

Investigative Activities -

Audit Activities -

Legal or Prosecutive Activities -

Cross-cutting Problems (if relevant) -

Results - Summarize results to date and whether results should be expected to improve without major changes.

ATTACHMENT A

OFFICE OF THE INSPECTOR GENERAL
DIVISION OF STATE FRAUD CONTROL

RECERTIFICATION FIELD GUIDE

A. MANAGEMENT REVIEW

1. Organization and Staffing
2. Coordination Activity
3. Facilities and Support Services
4. Results
5. Budget Review

B. INVESTIGATIONS

1. Qualifications and Recruitment of Unit Investigators
2. Training of Staff
3. Relations with other Professionals
4. Case Management
5. Investigative Techniques and Processes
6. Workload and Reporting
7. Security and Confidentiality

C. UNIT AUDIT CAPABILITY AND FISCAL INTEGRITY

1. Qualifications and Recruitment of Unit Auditors
2. Training of Unit Auditors
3. Relations with other Profesionals
4. Auditor Case Assignment
5. Unit use of Audit Programs and Techniques
6. Fiscal Integrity of Grant
7. Budget Review

D. ATTORNEY/PROSECUTION

1. Prosecution Authority
2. Criminal Penalties
3. Pleas/Trials
4. Sentencing Practices
5. Process Authority
6. Prosecutor Selection, Experience, etc.
7. Civil and Recovery Actions

E. APPENDICES

Appendix 1 - Entrance Conference Guide

Appendix 2 - Investigator Interview Guide

Appendix 3 - Relationships with Medicaid Agency - Interview Guide

A. MANAGEMENT REVIEW

1. Organization and Staffing

a. Location of Unit in State government:

-- in relation to Governor, Attorney General, local prosecutors, etc.; and

-- location within parent department.

b. Internal organization and chain of supervision.

c. Team approach and relations among the professionals.

d. Number of physical locations or branch offices.

e. Number of staff by profession and by location.

f. Workload in comparison to staffing.

g. Are all staff unit employees, or are there detailees, joint assignments, or other complications? If so, are the relations adequately documented and approved by the Office of Inspector General, HHS?

   (1) Review with he employees concerned how the arrangement works in practice; especially who supervises work.

   (2) Review compliance with paragraphs (j)(5)(iv) and (a) of regulations.

h. Review unit policy files, directions, and correspondence (especially with Medicaid agency and Attorney General).

i. Ae there separate staff and procedures for patient abuse or neglect cases? Are these cases normally worked or referred?

j. Are there separate staff and procedures for overpayment collection ? Does the unit normally attempt to collect or refer for collection?

2. Coordination/Liaison Activity

   a. Medicaid Agency--review whether "separate and distinct", whether memorandum of understanding is being followed, whether adequate screening and referrals take place, quality and quantity of referrals, recommendations by unit on improvements etc, referral criterial and procedures. Review with unit, and when possible, the Medicaid Agency the points covered in Attachment 3.

   b. Office of Investigations and Audit Agency, OIG.

   c. United States Attorneys, FBI, DEA, etc.

   d. Other State law enforcement offices.

   e. If unit refers for prosecution, review:

      --general arrangement for referrals, provision of assistance, prosecutor's assistance, State's Attorney General, etc.;

      --letters to all prosecutors, memoranda of understanding, etc.

   f. Adequacy of management controls (logs, "tickler" systems) to track cases and other matters (e.g. policy recommendations, requests for information) referred to other agencies for action.

3. Facilities and Support Services

   a. Clerical and paraprofessional support staff: adequacy and utilization.

   b. Adequacy and condition of the office space.

   c. Parking conditions and facilities.

   d. Telephone service.

   e. Office equipment: copy machines, calculators, computers, word processing, etc.

   f. Conference room/private interview room

   g. Supply room.

   h. Dictation facilities

   i. Heat, light and air.

   j. Library and subscriptions.

4 Results

a. Indictments.

b. Convictions and sentences.

c. Dollars recommended for recovery and other means of dollar savings.

d. Recommendations to Medicaid agency--how many, what nature, results, and follow-up; any assessment of their cost savings impact.

5. Budget Review

Review pending budget requests in light of actual activities and field situation. Review supervisor should assign items within special expertise of review staff members for review, but all team members should be alert to any relevant information.

B. INVESTIGATIONS

1. Qualifications and Recruitment of Unit Investigators

a. Review position descriptions (both official and from application for certification or recertification), resumes, and recruitment/selection policies.

b. Are the investigators qualified to carry out the unit's responsibilities in an effective and efficient manner?

c. Does the unit employ one or more senior investigators "with substantial experience in commercial or financial investigations who is capable of supervising and directing the investigation activities of the unit"?

d. What is adequacy of pay, etc. to attract and retain qualified staff?

e. What limitations are there on recruitment/ selection which unduly hamper ability of unit to attract and retain qualified staff?

f. Are the investigators peace officers? Are there limitations on their authority which impair their effectiveness?

2. Training of Staff

a. Entrance level, minimum

b. Supervised field training

c. Special schools, etc.

d. Staff meetings

e. Training materials: handbooks, subscriptions, circulars, etc.

f. Training plan

3. Relationship with Other Professionals

   a. How do investigators relate to other professionals:

      --institutional cases

      --practitioner cases

   b. Evaluate team approach as implemented and from investigator perspective. Do the Investigators have adequate access to attorneys and auditors (formally and informally)?

4. Case Management

   a. Receipt evaluation, and logging of referrals: what staff are assigned, procedures followed, criteria established; what criteria is there for opening cases and for a self-generated case?

   b. Quality of referrals (especially from Medicaid Agency)-- what proportion are blind leads which turn out to have no potential; what proportion need preliminary investigation; what proportion are well-developed leads with probable scheme identified and enough information to assign a priority; does Medicaid agency appear to be doing its job?

   c. Case assignment policies, priorities, case planning?

   d. Case tracking and routine reporting to management as to results, problems, and plans?

   e. Caseload per investigator--evaluate average and extreme, considering complexities of cases; evaluate staffing requirements and proposed increases in staffing.

   f. Is there a system which insures that convictions are referred to the Medicaid agency and HCFA for exclusion from Medicaid and Medicare, to licensing boards for license action, to peer associations for professional censure, etc.

   g. Tracking system for cases referred outside unit for action (e.g. patient abuse, overpayment collections, exclusion, license, etc.).

5. Investigative Techniques and Processes

   a. Evaluate investigator's knowledge of and use of standard investigative techniques and those advanced techniques relevant to Medicaid fraud investigations.

   b. Do the investigators have adequate access to providers' records, print-outs, Medicaid agency records, etc.?

6. Workload and Workload Reporting

   a. Evaluate average caseload per investigator, range of cases assigned to each investigator, backlog of cases unassigned, etc.

   b. Is there a reasonable workload for existing number of staff? For an increase? If there is a request for an increase in staff pending, does it seem reasonable?

   c. Are workload reports accurate (i.e. HCFA-54 form), and follow the approved definitions of "case", "recovery" ,etc. Does the unit seem to have a reasonable system for insuring that they are accurately and timely filed?

   d. Interviews with a reasonable sample of field investigators, using attachd guide modified to meet needs of the particular review.

7. Security and Confidentiality

   a. Physical security (control of access to office space, individual interview rooms)

   b. Document security (files and indices, practices)

   c. Evidence handling procedures

   d. Are there controls on access to patient information ("need to know"), security of such information within unit files, and is such information securely destroyed when no longer needed?

   e. Procedures for records destruction.

C. UNIT AUDIT CAPABILITY AND FISCAL INTEGRITY

1. Qualifications and Recruitment of Unit Auditors

a. Review position descriptions (official and from application), resumes, and recruitment and selection policies.

b. Are the auditors qualified to carry out the unit's duties and responsibilities in an effective and efficient manner?

c. Does the unit employ one or more experienced auditors capable of supervising the review of financial records and advising or assisting in the investigation of alleged fraud?

2. Training of Unit Auditors

a. What kinds of continuing professional education are made available and utilized by audit staff--university or association courses, consultation with other professionals on problems, supervisory training, on-the-job training with a more experienced unit, etc.

b. Are training needs of both experienced and inexperienced auditors being met? Are plans/expectations for the future training adequate?

c. Are auditors adequately informed as to Medicaid reimbursement rules and policies? Do they have and use currently updated CCH-Medicare-Medicaid Guide, set of Medicaid Manuals, set of State regulations, manuals, issuances, etc.? Have Medicaid agency personnel responsible for institutional reimbursement, etc., adequately briefed the auditors?

d. Are auditors experienced in or trained for witness interviews or other "investigative" activities?

3. Relations with other Professionals

a. How do auditors relate to other professionals on institutional cases and on other cases?

b. Do auditors act as investigators and conduct witness interviews, etc.? vice versa?

c. How frequently do auditors work on the same case in joint assignments with investigators and/or attorneys? What is relationship in such cases?

d. Evaluate team approach, especially from audit perspective--are there deleterious professional tensions?

4. Auditor Case Assignment

a. On what basis are institutions selected for an investigative audit by the unit? Review the Medicaid agency's audit activity and relation to unit audits. Does the reimbursement system allow for existence of "cost report" fraud?

b. Who determines audit case priority, assignment, and scope? What are policies for these decisions?

c. How are cases tracked and followed by management?

d. Caseload per auditor--evaluate average and extremes and; considering complexities of audits, etc. evaluate staffing requirements and especially any proposed increases in staffing.

e. Are unit's audits appropriate or are they performing a duplication of Single State Agency work?

5. Unit use of Audit Programs and Techniques

a. Does the unit have adequate general audit guides and GAO's standards for government auditors?

b. Are specific audit programs prepared for each institutional audit?

c. Adequacy of audit programs and instructions to audit staff on conduct of specific audits to determine if there is a basis for the suspected fraud and its extent and adequate controls to reasonably limit and focus audit scope.

d. Use of sampling techniques and statistical projections--especially for determination of overpayments.

e. Is there an auditor or other professional with an understanding of computer techniques for providing unit input in Medicaid agency detection efforts, etc.?

f. Review reporting to HHS on amount of overpayments collected and identified for collection--are these accurate and reasonably based?

6. Fiscal Integrity of Grant

a. Determine the procedures followed by the unit in receiving, recording, depositing, and disbursing grant funds. Are the responsibilities for these functions properly segregated?

b. Trace a number of transactions completely through the accounting system--from the point of origination to the preparation of the financial status report.

c. Determine whether employee time cards, purchase orders, travel orders, vendor invoices, travel vouchers, etc. are approved by the FCU Director; or are otherwise administratively controlled within the FCU. Does the FCU maintain a control ledger of costs which should have been charged to the grant? If so, is the ledger reconciled to reports of transactions which are received from the State agency's accounting office? Absence of such controls enhances the probability of non FCU costs being charged to the grant.

d. Determine whether purchase orders, vendor invoices, etc. require review and approval by other than FCU personnel. Such a control also reduces the likelihood of unallowable expenditures.

e. Obtain the financial status report for the period of review. Interview the individual who prepared the report. Determine the procedures and methodology used in accumulating data for the report. Assess the adequacy of the audit trail to the original source docmentation.

f. Verify the costs reported on line "E" of the financial status report to the first level in the audit trail; usually the preparer's supporting workpapers and/or expenditure control ledger. Also verify line "H", unliquidated obligations.

g. Compare actual expenditures to the budget. Determine the reasons for any major variances between budgeted and actual costs. Also determine whether the FCU obtained prior approval from the Division of State Fraud Control to purchase items or services requiring such approval.

h. Obtain two payroll registers which fall within the period of review. Compare the names of those paid with grant funds to an independent source listing of FCU personnel. Determine the reason(s) for any discrepancies. Also ascertain whether fringe benefit charges for these pay periods related only to FCU employees.

i. Obtain an inventory control listing of equipment purchased with grant funds. If an inventory listing is not maintained, review the file of equipment invoices and paid vouchers. Does the type and quantity of equipment items purchased appear reasonable in relation to the size and composition of the FCU, i.e., it would not appear reasonable to purchase 50 dictaphones for FCU containing only 25 employees. For major equipment items, assure that the items are actually on hand at the FCU. Also determine whether the proper procurement practices were followed.

j. Review contractual services charged to the grant, including consultant services. For each contract, determine whether a service was rendered to the FCU. Does the service provided appear reasonable in relation to the needs of the FCU, i.e., it would appear unreasonable to charge the grant with the total costs of remodeling an entire floor of office space if the FCU occupies only a small portion of that space. Determine whether the requirements for obtaining bids, if applicable, were adhered to.

k. Review travel vouchers and determine whether the travel was approved by an authorizing official. Were the travel costs incurred by an employee of the FCU?

l. The reviewer will probably find that charges for supplies, rentals, communications, etc. will not be broken out on the financial status report, but will be shown as "other" costs. The reviewer will need to establish an itemization of these costs. Depending on the materiality of each cost item, the reviewer should apply techniques similar to those in steps h - k, if applicable, to assess the appropriateness of these charges.

m. Review the state's draws under its letter of credit for compliance with Departmental Federal Assistance Financing System policies limiting draws to cover current expenditures.

n. Review inter-governmental charges for compliance with applicable regulations--especially note any charges for employees "detailed" to the unit from another agency, computer charges, contracts for professional services, etc.

o. Review "negotiated agreement" for indirect costs and ascertain that appropriate rate is charged to the grant. Verify that appropriate base is being used in calculation of indirect costs.

7. Budget Review

   a. During the rview of payroll registers referred to in 6.h. above, compare the rate of pay of individuals to the rate set in the budget request for the following period; if there are significant differences, determine reasons.

   b. During the review of equipment inventory referred to in 6.i. above, review the equipment requests of the proposed budget to determine if the unit already has reasonable quantities of the requested equipment or any other anomalies.

   c. During other fiscal integrity review steps, keep in mind comparable budget request items and note any anomalies with historical data.

D. ATTORNEY/PROSECUTION

1. Prosecution Authority

a. Does unit have statewide prosecution authority?

b. Does unit exercise statewide prosecution authority?

c. If unit refers cases to local prosecutors, what working relationships have been made with the local prosecutors:

--MOUs with all local prosecutors

--Letters or personal contacts

--Are unit attorneys made available to try the cases or assist

--When does unit contact prosecutor on case to be referred and what assistance is offered

--Any arrangements/agreements with any association of local prosecutors for peer pressure to achieve prosecutions, etc.

2. Criminal Penalties for Medicaid Fraud

a. Are there specific Medicaid fraud statutes? If so, give elements and penalties.

b. What general statutes might be used: fraud, attempt, theft, false statement, bribery, kickbacks, etc.?

c. Are evidentiary and/or criminal procedure rules unusual or provide unusual difficulties? Are there frequent evidentiary or procedural problems caused by Medicaid agency practices, etc.? Court backlog, etc.?

d. Have there been cases which could have been more effectively prosecuted in Federal court under Federal law (stronger penalties, easier rules, more sympathetic judges, or less prejudiced juries)? Might there be such?

e. Relationship with U.S. Attorney(s)--has a cooperative relationship been established? Are cases referred from unit to U.S. Attorney and vice versa? Are cases jointly or cooperatively prosecuted? Would U.S. Attorney allow unit (under supervision) to prosecute in Federal Court?

3. Do Most Prosecutions go to Trial, or are Pleas Accepted? Evaluation of Plea Bargaining.

4. Practices at Sentencing--Are Sentencing Memoranda Submitted? Oral Presentations? Is Sentencing a Part of Plea Bargaining?

5. Authorities for Compulsory Process and Access to Procedures Records:

   a. Administrative subpoena

   b. Grand jury

   c. Search warrant

   d. Provider agreements (LaSalle National Bank problem?)

   e. Unit problems of access or use of a, b, c, and d.

6. Prosecutor Selection, Experience/Qualifications, Training

   a. Selection criteria:

      --State unit or Office of Personnel Management

      --Who has selection authority

   b. Experience/qualifications evaluation:

      --Length and type of experience

      --Evaluated by Unit Director or outside authority

c. Training programs:

--Completed

--Type (State/Federal)

--Continuing legal education

--Specialized courses

7. Civil and Recovery Actions

a. Does unit attempt to collect overpayments it has identified or referred for collection?

--Cases criminally prosecuted? (All overpayments or just those claims which are the basis for criminal action? Is restitution requested as a part of sentence? Results?)

--Others?

b. What are normal bases for recovery action? (civil action--i.e. tort or contract--special statute, quantum meruit)? Are punitive damages or special penalties available? Compare to 31 USC 231 in terms of elements, penalties, and practicalities. For recovery actions, are projections from statistical samples made and admissable into evidence (e.g. as under Federal Rules of Evidence, Rules 702 - 705)?

c. Are there situations where a qui tam or other action under 31 USC 231-235 would be more effective than a State action? Has unit considered such?

d. Does unit track and insure proper follow-up on referrals for collection? Are administrative actions available to Medicaid agency and are they used?

e. Are interest and costs of investigation considered? Any legal basis for collection? Any efforts or success in their collection?

f. Any problems in insuring that all overpayments identified and penalties are effectively imposed and collected?

Appendix 1

ENTRANCE CONFERENCE GUIDE

I. Introduction and Purpose

- A. Personal Introductions
- B. Purposes of Visit
    - 1. Eligibility for continued certification and funding.
    - 2. Provide an outsider's perspective; identification of any problems in effectiveness, and provision of any possible assistance.
    - 3. Discuss any problems unit has with Federal regulations, our policies, etc.
    - 4. Where applicale, help unit get more cooperation from Medicaid agency.
    - 5. Learn from unit their better practices, etc. so we can pass them on to other units.
- C. Describe any special purposes or focus of review--problems that concern us, pecial review techniques, etc.
- D. Describe our general process:
    - 1. Office of Investigations representative will interview investigators, review investigative files, etc.
    - 2. Audit Agency representative will interview auditors, review audit workpapers, and conduct a fiscal integrity review.
    - 3. Division of State Fraud Control representative will interview attorneys and management, review legal materials and policy file, etc.
    - 4. We may visit Medicaid agency, or other State agency to review liaison problems, etc.
    - 5. We will hold an exit conference in which we will give you our observations and discuss what we see for the report.

6. Each participant will provide input for a draft report to the unit director; we will be honestly open to revise that draft based upon the unit's response before issuing final report.

7. The final report may contain recommendations. If so, we will expect a formal response that for each recommentation, either accepts it and gives a schedule for implementation, or rejects it and provides an alternative or gives an explanation.

II. The Unit Should Be Asked to Give an Overview for the Whole Team of the Unit

A. Current status

B. Organization written government

C. Internal organization including existence of any "details" of staff or prorating of time of any staff.

D. General case flow within unit.

E. Team approach.

F. Relation with the Medicaid Agency, local prosecutors, State Attorney General, Federal agencies.

G. Referrals: sources, number, quality

III. General

Ask the unit's management for their perspective of its most important strengths and weaknesses; any problems we can help with; any matter they would like us to review for possible recommendations or commendation.

Appendix 2

INVESTIGATOR INTERVIEW GUIDE

I. INTRODUCTION

- A. Personal Identification
- B. Team Member' Identification
- C. Explain Purpose and Methods
- D. Explain Confidentiality

II. ASSIGNMENTS/WORKLOAD

- A. How are they made?
- B. Too many or too few?
- C. Quality of assignment screening process?
- D. Geographic considerations?
- E. Suggestions for improvements.

III. CASE PLANNING

- A. How is investigation planned?
- B. Who reviews?
- C. Has plan usually been adequate?
- D. Has plan usually been followed?
- E. Suggestions for planning.

IV. SUPERVISION

- A. Length of time in Unit?
- B. Type of supervision received: field, continuing case control, phone, office?

C. Quality of each type?

D. Supervisor's time allocation?

E. Suggestions.

V. TRAINING

A. What training has been received?

B. Quality of training?

C. Training materials and self-instruction?

VI. PERFORMANCE

A. Supervisory appraisals?

B. Self appraisal?

VII. OVERALL OPERATION

A. Staff support, suggestions?

B. Case handling?

C. Reports?

D. Liaison?

E. Other.

VIII. EVALUATION OF ATTORNEYS/PROSECUTORS

A. Experienced

B. Supportive

IX. RECOMMENDATIONS

Name of Investigator Interviewed: ________________________

Date of Interview: ______________ Interviewed by: _________

Appendix 3

RELATIONS WITH MEDICAID AGENCY - INTERVIEW GUIDE

1. Detection efforts--number, qualifications, and functions of assigned staff; vacancies on coverage of provider types.

2. Referrals--number, amount of work done prior to referral, quality, composition of provider types, timeliness (after complaint received or problem detected and statute of limitations).

3. Responses to unit requests for information--timeliness, responsiveness, discussion of alternatives.

4. Liaison committee, degree of formality of relations, unit access to staff.

5. Reaction to unit's program recommendations; openness to pre-issuance review of policy changes, etc.

6. Attitude to unit case development efforts.

7. Any problems Medicaid agency has with unit.

and which provide effective coordination of activities between the entity and such office with respect to the detection, investigation, and prosecution of suspected criminal violations relating to the program under this title.

"(2) The entity is separate and distinct from the single State agency that administers or supervises the administration of the State plan under this title.

"(3) The entity's function is conducting a statewide program for the investigation and prosecution of violations of all applicable State laws regarding any and all aspects of fraud in connection with any aspect of the provision of medical assistance and the activities of providers of such assistance under the State plan under this title.

"(4) The entity has procedures for reviewing complaints of the abuse and neglect of patients of health care facilities which receive payments under the State plan under this title, and, where appropriate, for acting upon such complaints under the criminal laws of the State or for referring them to other State agencies for action.

"(5) The entity provides for the collection, or referral for collection to a single State agency, of overpayments that are made under the State plan to health care facilities and that are discovered by the entity in carrying out its activities.

"(6) The entity employs such auditors, attorneys, investigators, and other necessary personnel and is organized in such a manner as is necessary to promote the effective and efficient conduct of the entity's activities.

Application and annual reports, submittal to Secretary.

"(7) The entity submits to the Secretary an application and annual reports containing such information as the Secretary determines, by regulation, to be necessary to determine whether the entity meets the other requirements of this subsection.".

42 USC 1395b-1.

(d) Section 402(a)(1) of the Social Security Amendments of 1967 (Public Law 90-248), as amended by section 222 of the Social Security Amendments of 1972 (Public Law 92-603), is amended—

(1) by striking out "and" at the end of subparagraph (H);

(2) by striking out the period at the end of subparagraph (I) and inserting in lieu thereof "; and"; and

(3) by adding after subparagraph (I) the following new subparagraph:

"(J) to develop or demonstrate improved methods for the investigation and prosecution of fraud in the provision of care or services under the health programs established by the Social Security Act.".

42 USC 1305.
Effective date.
42 USC 1396b note.
Regulations.

(e)(1) The amendment made by subsection (a) shall apply with respect to calendar quarters beginning after September 30, 1977.

(2) The Secretary of Health, Education, and Welfare shall establish such regulations, not later than ninety days after the date of enactment of this Act, as are necessary to carry out the amendments made by this section.

FUNDING OF STATE MEDICAID FRAUD CONTROL UNITS

42 USC 1396b

SEC. 17. (a) Section 1903(a) of the Social Security Act is amended by redesignating paragraph (6) as paragraph (7) and by inserting after paragraph (5) the following new paragraph:

"(6) subject to subsection (b)(3), an amount equal to 90 per centum of the sums expended during each quarter beginning on or after October 1, 1977, and ending before October 1, 1980, with respect to costs incurred during such quarter (as found necessary by the Secretary for the elimination of fraud in the provision and administration of medical assistance provided under the State plan) which are attributable to the establishment and operation of (including the training of personnel employed by) a State medicaid fraud control unit (described in subsection (q)); plus".

(b) Section 1903(b) of such Act is amended by inserting after paragraph (2) the following new paragraph:

"(3) The amount of funds which the Secretary is otherwise obligated to pay a State during a quarter under subsection (a)(6) may not exceed the higher of—

"(A) $125,000, or

"(B) one-quarter of 1 per centum of the sums expended by the Federal, State, and local governments during the previous quarter in carrying out the State's plan under this title.".

"State medic fraud control unit."

(c) Section 1903 of such Act is further amended by inserting after subsection (p) (added by section 11(a) of this Act) the following new subsection:

Certification requirements

"(q) For the purposes of this section, the term 'State medicaid fraud control unit' means a single identifiable entity of the State government which the Secretary certifies (and annually recertifies) as meeting the following requirements:

"(1) The entity (A) is a unit of the office of the State Attorney General or of another department of State government which possesses statewide authority to prosecute individuals for criminal violations, (B) is in a State the constitution of which does not provide for the criminal prosecution of individuals by a statewide authority and has formal procedures, approved by the Secretary, that (i) assure its referral of suspected criminal violations relating to the program under this title to the appropriate authority or authorities in the State for prosecution and (ii) assure its assistance of, and coordination with, such authority or authorities in such prosecutions, or (C) has a formal working relationship with the office of the State Attorney General and has formal procedures (including procedures for its referral of suspected criminal violations to such office) which are approved by the Secretary

Subpart D—State Medicaid Frau
Control Units

**§ 455.300 State medicaid fraud co
units.**

(a) *Definitions.* As used in this
tion, unless otherwise indicated by
context:

"Employ" or "employee", as the
text requires, means full-time dut
tended to last at least a year. I
cludes an arrangement whereby a
dividual is on full-time detail or as
ment to the unit from another go
ment agency, if the detail or as
ment is for a period of at least 1
and involves supervision by the un

"Provider" means an individu
entity which furnishes items or
ices for which payment is cla
under medicaid.

"Unit" means the State me
fraud control unit.

(b) *Scope and purpose.* This se
implements section 1903(
1903(b)(3), and 1903(q) of the
Security Act, as amended by the
care-Medicaid Anti-Fraud and
Amendments (Pub. L. 95-142 of
ber 25, 1977). The statute auth

the Secretary to pay a State 90 percent of the costs of establishing and operating a State medicaid fraud control unit, as defined by the statute, for the purpose of eliminating fraud in the State medicaid program.

(c) *Basic requirement.* A State medicaid fraud control unit must be a single identifiable entity of the State government certified by the Secretary as meeting the requirements of paragraphs (d) through (g) of this section.

(d) *Organization and location requirements.* Any of the following three alternatives is acceptable:

(1) The unit is located in the office of the State attorney general or another department of State government which has statewide authority to prosecute individuals for violations of criminal laws with respect to fraud in the provision or administration of medical assistance under a State plan implementing title XIX of the Act; or

(2) If there is no State agency with statewide authority and capability for criminal fraud prosecutions, the unit has established formal procedures which assure that the unit refers suspected cases of criminal fraud in the State medicaid program to the appropriate State prosecuting authority or authorities, and provides assistance and coordination to such authority or authorities in the prosecution of such cases; or

(3) The unit has a formal working relationship with the office of the State attorney general and has formal procedures for referring to the attorney general suspected criminal violations occurring in the State medicaid program and for effective coordination of the activities of both entities relating to the detection, investigation and prosecution of those violations. Under this requirement, the office of the State attorney general must agree to assume responsibility for prosecuting alleged criminal violations referred to it by the unit. However, if the attorney general finds that another prosecuting authority has the demonstrated capacity, experience and willingness to prosecute an alleged violation, he may refer a case to that prosecuting authority, as long as his office maintains oversight responsibility for the prosecution and for coordination between the unit and the prosecuting authority.

(e) *Relationship to, and agreement with, the medicaid agency.* (1) The unit must be separate and distinct from the medicaid agency.

(2) No official of the medicaid agency shall have authority to review the activities of the unit or to review or overrule the referral of a suspected criminal violation to an appropriate prosecuting authority.

(3) The unit shall not receive funds paid under this section either from or through the medicaid agency.

(4) The unit shall enter into an agreement with the medicaid agency under which the medicaid agency will agree to comply with all requirements of § 455.21(a)(2).

(f) *Duties and responsibilities of the unit.* (1) The unit shall conduct a statewide program for investigating and prosecuting (or referring for prosecution) violations of all applicable State laws pertaining to fraud in the administration of the medicaid program, the provision of medical assistance, or the activities of providers of medical assistance under the State medicaid plan.

(2) The unit shall also review complaints alleging abuse or neglect of patients in health care facilities receiving payments under the State medicaid plan and may review complaints of the misappropriation of patient's private funds in such facilities.

(i) If the initial review indicates substantial potential for criminal prosecution, the unit shall investigate the complaint or refer it to an appropriate criminal investigative or prosecutive authority.

(ii) If the initial review does not indicate a substantial potential for criminal prosecution, the unit shall refer the complaint to an appropriate State agency.

(3) If the unit, in carrying out its duties and responsibilities under paragraphs (f) (1) and (2) of this section, discovers that overpayments have been made to a health care facility or other provider of medical assistance under the State medicaid plan, the unit shall either attempt to collect such overpayment or refer the matter

to an appropriate State agency for collection.

(4) Where a prosecuting authority other than the unit is to assume responsibility for the prosecution of a case investigated by the unit, the unit shall insure that those responsible for the prosecutive decision and the preparation of the case for trial have the fullest possible opportunity to participate in the investigation from its inception and will provide all necessary assistance to the prosecuting authority throughout all resulting prosecutions.

(5) The unit shall make available to Federal investigators or prosecutors all information in its possession concerning fraud in the provision or administration of medical assistance under the State plan and shall cooperate with such officials in coordinating any Federal and State investigations or prosecutions involving the same suspects or allegations.

(6) The unit shall safeguard the privacy rights of all individuals and shall provide safeguards to prevent the misuse of information under the unit's control.

(g) *Staffing requirements.* (1) The unit shall employ sufficient professional, administrative, and support staff to carry out its duties and responsibilities in an effective and efficient manner. The staff must include:

(i) One or more attorneys experienced in the investigation or prosecution of civil fraud or criminal cases, who are capable of giving informed advice on applicable law and procedures and providing effective prosecution or liaison with other prosecutors;

(ii) One or more experienced auditors capable of supervising the review of financial records and advising or assisting in the investigation of alleged fraud;

(iii) A senior investigator with substantial experience in commercial or financial investigations who is capable of supervising and directing the investigative activities of the unit.

(2) The unit shall employ, or have available to it, professional staff who are knowledgeable about the provision of medical assistance under title XIX and about the operation of health care providers.

(h) *Applications, certification, and recertification*—(1) *Initial application.* In order to receive FFP under this section, the unit must submit to the Secretary, an application approved by the Governor, containing the following information and documentation.

(i) A description of the applicant's organization, structure, and location within State government, and an indication of whether it seeks certification under paragraph (d)(1), (d)(2), or (d)(3) of this section;

(ii) A statement from the State attorney general that the applicant has authority to carry out the functions and responsibilities set forth in this section. If the applicant seeks certification under paragraph (d)(2) of this section, the statement must also specify either that there is no State agency with the authority to exercise statewide prosecuting authority for the violations with which the unit is concerned, or that, although the State attorney general may have common law authority for statewide criminal prosecutions, he has not exercised that authority.

(iii) A copy of whatever memorandum of agreement, regulation, or other document sets forth the formal procedures required under paragraph (d)(2) of this section or the formal working relationship and procedures required under paragraph (d)(3) of this section;

(iv) A copy of the agreement with the medicaid agency required under paragraph (e) of this section;

(v) A statement of the procedures to be followed in carrying out the functions and responsibilities of this section;

(vi) A projection of the caseload and a proposed budget for the 12-month period for which certification is sought; and

(vii) Current and projected staffing, including the names, education, and experience of all senior professional staff already employed and job descriptions, with minimum qualifications, for all professional positions.

(2) *Conditions for, and notification of certification.* (i) The Secretary will approve an application only if he has specifically approved the applicant's

formal procedures under paragraph (d)(2) or (d)(3) of this section, if either of those provisions is applicable, and has specifically certified that the applicant meets the requirements of paragraph (d) of this section.

(ii) The Secretary will promptly notify the applicant whether the application meets the requirements of this section and is approved. If the application is not approved, the applicant may submit an amended application at any time. Approval and certification will be for a period of 1 year.

(3) *Conditions for recertification.* In order to continue receiving payments under this section, a unit must submit a reapplication to the Secretary at least 60 days prior to the expiration of the 12-month certification period. A reapplication must:

(i) Advise the Secretary of any changes in the information or documentation required under paragraph (h)(1) (i) through (v) of this section.

(ii) Provide projected caseload and proposed budget for the recertification period; and

(iii) Include or incorporate by reference the annual report required under paragraph (i) of this section.

(4) *Basis for recertification.* (i) The Secretary will consider the unit's reapplication, the reports required under paragraph (i) of this section, and any other reviews or information he deems necessary or warranted, and will promptly notify the unit whether he has approved the reapplication and recertified the unit.

(ii) In reviewing the reapplication, the Secretary will give special attention to whether the unit has used its resources effectively in investigating cases of possible fraud, in preparing cases for prosecution, and in prosecuting cases or cooperating with the prosecuting authorities.

(i) *Reporting requirements*—(1) *Annual report.* At least 60 days prior to the expiration of the certification period, the unit shall submit to the Secretary a report covering the last 12 months (the first 9 months of the certification period for the first annual report), and containing the following information:

(i) The number of investigations initiated and the number completed or closed, categorized by type of provider;

(ii) The number of cases prosecuted or referred for prosecution; the number of cases finally resolved and their outcomes; and the number of cases investigated but not prosecuted or referred for prosecution because of insufficient evidence;

(iii) The number of complaints received regarding abuse and neglect of patients in health care facilities; the number of such complaints investigated by the unit; and the number referred to other identified State agencies.

(iv) The number of recovery actions initiated by the unit; the number of recovery actions referred to another agency; the total amount of overpayments identified by the unit; and the total amount of overpayments actually collected by the unit;

(v) The number of recovery actions initiated by the medicaid agency under its agreement with the unit; and the total amount of overpayments actually collected by the medicaid agency under this agreement;

(vi) Projections for the succeeding 12 months for items listed in paragraphs (i)(1) (i) through (v) of this section;

(vii) The costs incurred by the unit, by major budget category; and

(viii) A narrative that evaluates the unit's performance; describes any specific problems it has had in connection with the procedures and agreements required under this section; and discusses any other matters that have impaired its effectiveness.

(2) The unit shall also provide any additional reports that the Secretary requests, and shall comply with any measures the Secretary deems necessary to assure the accuracy and completeness of all reports required under this paragraph (i).

(j) *Federal financial participation (FFP)*—(1) *Rate of FFP.* Subject to the limitations specified in this paragraph, the Secretary will reimburse each certified State medicaid fraud control unit, by an amount equal to 90 percent of the costs incurred by that unit which are attributable to carrying out its functions and responsibilities under this section. The costs subject to reimbursement will be determined under 45 CFR part 74, except as provided otherwise in this part or in the grant award.

(2) *Basis and period of payment.* (i) Payment will be made for each quarter, based on quarterly reports submitted by the unit in the format and containing the information requested by the Secretary.

(ii) Payments are available for each quarter during fiscal years 1978, 1979, and 1980.

(iii) The Secretary may grant certification retroactive to the date on which the unit first met all the requirements of the statute and of this section. For any quarter with respect to which the unit is certified, the Secretary will provide reimbursement for the entire quarter.

(3) *Amount of FFP.* The amount paid during any quarter shall not exceed the higher of $125,000 or one-quarter of 1 percent of the sums expended by the Federal, State, and local governments during the previous quarter in carrying out the State medicaid program.

(4) *Costs subject to FFP.* FFP is available under this section for the expenditures attributable to the establishment and operation of the unit, including the cost of training personnel employed by the unit. Reimbursement shall be limited to costs attributable to the specific responsibilities and functions set forth in this section in connection with the investigation and prosecution of suspected fraudulent activities and the review of complaints of alleged abuse or neglect of patients in health care facilities. Establishment costs are limited to clearly identifiable costs of personnel that:

(i) Devote full time to the establishment of the unit which does achieve certification; and

(ii) Continue as full-time employees after the unit is certified.

All establishment costs will be deemed made in the first quarter of certification.

(5) *Costs not subject to FFP.* FFP is not available under this section for expenditures attributable to:

(i) The investigation of cases involving program abuse or other failures to comply with applicable laws and regulations, if these cases do not involve substantial allegations or other indications of fraud;

(ii) Efforts to identify situations in which a question of fraud may exist, including the screening of claims, analysis of patterns of practice, or routine verification with recipients of whether services billed by providers were actually received;

(iii) The routine notification of providers that fraudulent claims may be punished under Federal or State law;

(iv) The performance by a person other than a full-time employee of the unit of any management function for the unit, any audit or investigation, any professional legal function, or any criminal, civil or administrative prosecution of suspected providers;

(v) The investigation or prosecution of cases of suspected recipient fraud not involving suspected conspiracy with a provider; or

(vi) Any payment, direct or indirect, from the unit to the medicaid agency, other than payments for the salaries of employees on detail to the unit.

MEMORANDUM

Department of Health and Human Se
Office of the Inspector Genera
[redacted]

Joseph J. Piazza, Director
Division of State Fraud Control
Office of Inspector General, HHS

DATE: [redacted]

OM : [redacted]

BJECT: Transmittal of Results of [redacted] Survey of Audit Capability and Fiscal Integrity of the [redacted] Medicaid Fraud Control Unit - Audit Control No. [redacted]

The results of the above mentioned survey are included in attachments hereto. Attachment I covers audit capabilities while Attachment II addresses the Unit's fiscal integrity. If you have any questions, please contact [redacted] Manager of our [redacted] Branch at (FTS) [redacted]

Attachments - as stated

Summary of Results of Survey of Fiscal Integrity at the [redacted] Fraud Control Unit ([redacted]FCU) - [redacted]

1. Accounting System and Procedures - [redacted]FCU is part of the State Department of Attorney General, which, through its Business Office, provides accounting services for the grant. The Business Office uses the [redacted] accounting system. A separate account is maintained for total [redacted]FCU expenditures and subsidiary accounts for recording expenditures by budgeted line items. In addition, the [redacted]FCU secretary maintains a control account and subsidiary accounts to record [redacted]FCU expenditures by budget line items such as salaries, travel, equipment, supplies, etc.

   Cash withdrawals are initiated by [redacted]FCU on a monthly basis, while expenditures are recorded by the Business Office and the State Treasury Department receives and disburses funds. The responsibilities for these functions are properly segregated. However, [redacted]FCU based its Federal cash withdrawals on estimates of 100 percent of monthly expenses rather than 90 percent, which, per the notice of grant award, is the Federal share of expenses. This happened because funds to pay for the non-Federal share of fiscal year 1980 expenses [redacted] were not made available until August 1980. As a result, [redacted]FCU used Federal funds to pay for 100 percent of [redacted]FCU fiscal year 1980 expenses

   Recommendations - [redacted]FCU should establish procedures to insure that future withdrawals of Federal funds are limited to 90 percent of estimated monthly expenses. In addition, fiscal year 1981 Federal withdrawals should amount to only 90 percent of total fiscal year 1981 expenses less the amount of [redacted] in Federal funds withdrawn and not used during fiscal year 1980.

2. Verification of Costs - We reviewed documentation and other data supporting 30 expenditures related to rental, office supplies, equipment, other direct expenses and travel. We traced these expenditures from the Financial Status Report to [redacted]FCU's subsidiary accounts to vouchers. All supporting data was easily located and we found that the expenditures were related to the grant.

   RECOMMENDATIONS: NONE

3. Approvals - Employee time cards and travel vouchers are approved by the Director of the [redacted]FCU and reviewed by a Research Assistant in the Business Office. Purchase orders are approved by the Director of the [redacted]FCU, the Business Office and the State's Bureau of Purchases. Vendors' invoices are signed by the [redacted]FCU's Director and the Manager of the Business Office.

   RECOMMENDATIONS: NONE

4. Preparation of Financial Reports and Verification of Net Outlays and Unliquidated Obligations - [redacted]FCU's secretary prepares the Financial Status Reports using the State Controller's Monthly Analysis of Income and Expenditure Report, which provides information on total year-to-date [redacted]FCU expenditures and the [redacted]FCU's control account. The net outlays to-date are taken from the Monthly Analysis on Income and Expenditures Report, while total unliquidated obligations is the difference between expenditures per the Monthly Analysis on Income and Expenditures Report (prepared on a cash basis) and [redacted]FCU's control account (prepared on an accrual basis). However, a monthly reconciliation of the [redacted]FCU's control account to the State's Monthly Analysis of Income and Expenditures Report is not performed. The first and only reconciliation was performed by [redacted]FCU's auditor in May 1980 and disclosed several small expenditures not related to [redacted]FCU but charged to [redacted]FCU on the State records. These unrelated expenditures were subsequently charged to the proper accounts.

Recommendation:- We believe [redacted]FCU should reconcile, on a monthly basis, its control account to the State's Monthly Analysis of Income and Expenditures Report in order to insure the expenses are charged to the proper accounts.

5. Comparison of Budget to Actual - The only budget category to incur an overrun for fiscal year 1980 was travel - for [redacted]. However, the Division of State Fraud Control will allow [redacted]FCU to adjust its individual budget categories without approval, as long as the total grant award is not exceeded.

RECOMMENDATIONS- NONE

6. Payroll - We reviewed 3 bi-weekly payrolls and found them to be acceptable with the exception of one accounting clerk in the Business Office. In this respect, this individual devoted only about 10 percent of her time to the [redacted]FCU grant, but was charged 100 percent ([redacted]) to the [redacted]FCU grant. This occurred because the Business Office, a general support function within the Department of the Attorney General, has not developed a cost allocation plan to distribute support costs to the various programs within the office. We are not taking exception, at this time, to any portion of the accounting clerk's salary because there are two other individuals in the Business Office, namely the Research Assistant and the Business Manager, who stated that they perform functions benefitting [redacted]FCU. However, the [redacted]FCU grant is not charged for the appropriate share of such services.

Recommendation - The Business Office should develop a cost allocation plan to insure that the [redacted]FCU is charged in proportion to benefits received for Business Office expenses.

Attachment I
Page 3 of 3

7. Equipment - None of the office furniture or equipment purchased under the [redacted]FCU program had identification stickers. Further, the inventory control listing maintained by the [redacted]FCU was incomplete with respect to office equipment such as typewriters, dictaphones, transcribers and calculators.

   Recommendations - [redacted]FCU should install an identification sticker system, showing source of funding, employee name if assigned, and date of purchase. Further, the inventory control list should include all items of office equipment as well as office furniture purchased under the program.

8. Transportation - [redacted]FCU purchased [redacted] cars and leased [redacted] others with funds from the Federal grant. We found that [redacted]FCU maintained adequate records on the use of these cars to insure that they were used for business purposes only.

   RECOMMENDATIONS: NONE

Attachment II
Page 1 of 2

Summary of Results of Survey of Audits Performed by the [redacted] Fraud Control Unit ([redacted]FCU) - [redacted]

1. Personnel Qualifications - One auditor is employed by [redacted]FCU. He has a good educational and work background. He has a Bachelor's degree in Business Administration with a major in Accounting and previously worked for [redacted] Department of Human Services as an auditor.

2. Training - The auditor has attended three seminars relating to the identification of fraud. However, [redacted]FCU did not maintain a resume of training.

   Recommendation - Resumes of training should be developed, showing attendance at meetings and training sessions, objectives of the training, sponsorships, and dates of training so that an inventory of training and skills is available.

3. Audit Programs (Written) - The auditor, prior to starting an assignment, meets with the Investigator in charge of the case to determine general areas to be reviewed. Workpapers are not indexed and consist of memos of conversations and schedules developed to analyze accounts and expenditures. However, the auditor's conclusions are not always evident nor are formal audit programs developed to show: objectives, criteria, estimated days, actual days, and workpaper references.

   Recommendations - Auditor's conclusions should be clearly evidenced on all workpapers, and audit programs should be written for each assignment in order to identify the scope of such audit effort. In addition, the auditor should index, reference and cross-reference workpapers for easy access of data.

4. Case Assignment, Review and Management - The auditor's current workload consists of five cases (three as an Auditor and two in an investigative capacity). The [redacted]FCU Director, because of the small staff, assigns the Auditor to cases. Although the Auditor continually discusses his progress with the Investigators and Director, there is no evidence that Auditor's workpapers are reviewed.

   Recommendation - All auditors' workpapers should be initialled by reviewers.

Attachment II
Page 2 of 2

5. Other - The auditor does not use either of the following documents:

   A. "Standards for Audits of Governmental Organizations, Programs, Activities and Functions," dated 1972.

   B. "Self-Evaluation Guide for Governmental Audit Organizations," dated 1976.

Both of these documents were prepared by the United States General Accounting Office and are available at the U.S. Government Bookstores or Printing Office. We believe they are important to an audit organization and will assist the auditor in the conduct of audit assignments.

Recommendation - We recommend that the auditor obtain these documents and implement them where appropriate.

Attachment III
Page 1 of 1

Summary of Results of Budget Review of the [redacted] Fraud Control Unit's ([redacted]FCU's) 1981 Budget - [redacted]

As a means of determining the reasonableness of the [redacted]FCU's submitted fiscal year 1981 budget, we (1) determined the reasons for significant variances between fiscal year 1980 budget and fiscal year 1980 expenses, and (2) compared the fiscal year 1981 submitted budget to fiscal year 1980 expenses.

[redacted]FCU's fiscal year 1980 expenses were below budget primarily because (1) the auditor and one investigator were on the payroll for only six months, (2) the legal secretary was employed only 10 months, and (3) other direct costs such as rent, telephone, xerox, and witnesses were under budget.

The fiscal year 1981 budget exceeds fiscal year 1980 expenses primarily because of personnel costs. In this respect, the personnel not employed for a full year in 1980 are budgeted for a full year in 1981 and three additional staff are budgeted (Auditor, Investigator, and Attorney). Salary levels are in line with current State levels. However, we did not make a determination whether the additional staff is needed for fiscal year 1981 as this is the responsibility of the Division of State Fraud Control.

We feel that [redacted]FCU's fiscal year 1981 budget of [redacted] is reasonable except for [redacted] in air travel which the [redacted]FCU Director agrees is excessive. In addition, other costs include [redacted] for witnesses, court reporters, etc., for which we are unable to render an opinion because [redacted]FCU's Director could not provide support to show the extent to which these costs will be incurred.

Recommendations - The budget should be reduced by [redacted] for air travel. Further, before the Division of State Fraud Control accepts the [redacted] for witnesses, court reporters, etc., the [redacted]FCU should submit documentation to support this estimate.

ENCLOSURE 3

Form Approved
OMB No. 0938-0197

QUESTIONNAIRE

State Medicaid Agency Fraud and Abuse Control Activities

1. In the letter transmitting this questionnaire, we provide a brief description of what we believe are surveillance and utilization review functions. We recognize that the function associated with this unit may vary somewhat from State to State. Is the main function of the unit in your State; (a) a management function - cost control via examination of policy and review of internal operations, or (b) control of fraud and abuse? Please estimate the time spent in each function.

_________ percentage management/cost control

_________ percentage fraud and abuse

2. a. Is the S/UR unit in your State responsible for screening and detecting instances of institutional and noninstitutional provider fraud?

Percent of time - institutional _____

Percent of time - noninstitutional _____

No discrete S/UR ( )

b. If you have no discrete S/UR unit, please identify the entities responsible for the above activity with respect to each type of provider, and how fraud and abuse leads are produced?

3. If you have a State Medicaid Fraud Control Unit, how many referrals have been made by the Medicaid State agency for health provider fraud investigation in the past year? (If the Medicaid State agency does its own health provider fraud investigations, how many were conducted within the agency?)

4. How many health provider Medicaid fraud indictments and convictions have there been in the past year resulting from State Medicaid agency referrals?

   a. Indictments ______

   b. Convictions ______

5. At the present time, is the Medicaid State agency able to respond to the State Medicaid Fraud Control Unit's needs? (Answer only if you heve a certified fraud control unit).

   a. What percent of FCU workload is generated by State XIX agency referrals? ___

   b. Are there a sufficient number of referrals? ___

   c. Are the referrals well-founded and well documented? ___

   d. Estimate the percentage of referrals that on preliminary review are determined to be inappropriate or not worth pursuing. ___

   e. Is the State Medicaid agency able to provide computer-based information when requested by the FCU? ___

6. What changes, if any, in policy, emphasis, or priority at the Federal level would you suggest in helping the States become more effective in Medicaid fraud and abuse control?

7. Does the S/UR function in your State command a high priority?

   a. If you answered yes, please provide a rationale.

   b. If you answered no, please elaborate.

8. How can we work together to heighten that priority?

   Could S/UR efficiency be improved and fraud referrals increased by the joint development of model computer screens?

9. To what extent has your State been successful in using computer screens to discover fraud and abuse?

10. As nearly as possible, please provide the information requested below on past, current, and projected staffing and expenditure levels to support each of the following activities. (We recognize that your existing management and budgeting processes may not allow for precise data. Therefore, approximations, where necessary, are acceptable.)

	Most Recent Closed Fiscal Year (FY)		Current FY		Next FY	
	Staff	Budget	Staff	Budget	Staff	Budget
a. Profiling techniques and analysis to isolate potential utilization problems or other problems which could be viewed as fraud or abuse.						
b. Review and adjudication by medical or paramedical staff to determine whether utilization problems exist, level of such problems, and action taken to address such problems.						
c. Field work performed to determine validity of complaints which suggest provider fraud or abuse may be occurring and/or field work performed following the production of profile reports.						
d. State staff directly involved in conducting fiscal audits or supervising audit firms under contract with the State.						
e. Expenditures for audit firms to conduct fiscal audits necessary to determine appropriateness of reported provider costs.						

11. If there are other remarks you would like to provide which relate to the topic of Medicaid fraud and abuse, please do so.

QUESTIONS BY SENATOR DOLE AND NELSON SABATINI'S RESPONSES

Question:

There is considerable concern about Social Security payments being made to deceased people. Aside from the information received from HCFA, do you have any information from your new quality control system regarding unreported deaths of Social Security beneficiaries?

Do we really know the magnitude of this problem?

Response:

During the last two sample periods completed (October 1978 - March 1979 and April - September 1979), our quality assurance system, which reviews a random sample of cases receiving Retirement and Survivors' Insurance (RSI) benefits, identified only three cases out of about 6,000 cases reviewed where RSI payments were made to deceased individuals. In all of these cases, the deaths had been voluntarily reported to SSA, but the adjustment was not made timely enough to correct the payment for the sample month. Our quality assurance system indicates that unreported deaths occur infrequently in the SSI program, too.

While the quality review system does not allow us to estimate the magnitude of the problem (due to the infrequent occurrence of this type of error in our sample), the findings of the HCFA/SSA death report matching study indicate that unreported deaths are a source of misspent funds, and we are taking a variety of steps to assure timely and accurate termination of benefits when deaths occur. These steps include:

- Maintenance of an ongoing HCFA/SSA data interchange and continued efforts to assure that appropriate action on death reports from HCFA is taken.
- Establishment (where possible) of a limited death-record matching operation in which certain SSA records would be compared with death records held by some States. (Such matching operations are prohibited by privacy laws in some States.)
- Review of existing systems which match SSA data with other agencies' records (e.g., with Veterans Administration and Office of Personnel Management) to determine if they could be used in the detection of previously unreported deaths.
- Investigation of the availability of death records from other Federal agencies.

SSA/OLRP
3/19/82

Questions:

1. What do you know about the number of illegal aliens getting benefits?
2. Do you have any procedures to prevent these people from collecting benefits?
3. Do you think that tamper-proof cards would help reduce the number of illegal aliens working and qualifying for benefits?

Responses:

1. Data regarding the number of undocumented aliens who receive Social Security benefits do not exist. There is no requirement in the Social Security law that a person have a certain citizenship or alien status to qualify for Social Security benefits, and therefore SSA does not require evidence of citizenship or alien status from applicants for Social Security benefits.

2. Since the law permits payment of Social Security benefits to undocumented aliens, we have no authority or reason to prevent payments to these people. A fundamental feature of the Social Security program has always been that, if a person has worked long enough in covered employment to be insured, Social Security benefits are payable to the worker (and to qualified auxiliaries or survivors) regardless of the worker's (or the family member's) citizenship or alien status. Further, in nearly all cases Social Security coverage is based on whether the job is covered under Social Security—the legality of the worker's status is usually immaterial in determining whether the earnings are covered.

   In summary, the fact that a person is an alien illegally in the U.S.—or legally in the U.S. but not permitted to work here—is not material insofar as Social Security coverage and benefits are concerned. Under Social Security law, if the job is covered under Social Security, the individual holding that job pays Social Security taxes, receives Social Security credits, and can get Social Security benefits if he or she works long enough to become insured.

   SSA has explored the idea of prohibiting the payment of benefits to undocumented aliens but, for a variety of reasons, no satisfactory proposal has yet been devised. These reasons include the philosophical and legal concerns about an alien worker's right to benefits because of the Social Security taxes he/she has paid and concerns about violating treaty agreements which the U.S. has with several countries.

   However, while eligibility for benefits under the Social Security program is based on earnings from covered employment or self-employment, a Social Security number (SSN) is required for employment in order to get credit for earnings. And, in 1972, the Social Security Act was amended to provide that SSN's will, to the extent practicable, be issued to aliens who are lawfully admitted to the U.S. for permanent residence or under other authority of law permitting them to work in the U.S., and to other aliens at such time as their status is so changed as to make it lawful for them to engage in such employment. Consequently, the SSN is the mechanism SSA has used to reduce the number of illegal aliens obtaining jobs. SSA's efforts in this area also should reduce the possibility of illegal aliens obtaining the work credits needed to qualify for Social Security benefits. SSA's initiatives include the following actions:

   - Training is being provided for SSA field employees handling (SSN) applications to enable them to recognize counterfeit and altered immigration documents, birth certificates and other records presented as evidence of age, identity or citizenship or legal alien status, which is needed to secure an SSN. (Offices where this training has been given have reported that illegal aliens have been turned away or apprehended by the Immigration and Naturalization Service after presenting counterfeit documentation to SSA);

- A prominent legend--"Not Valid for Employment"--is being added in selected field offices to the face of SSN cards issued for nonwork purposes to legal aliens who do not have work authorization in the U.S., and this change will be implemented in all offices in the next few months; and
- National implementation has begun of a process which will speed SSN issuance by transmitting the application data by wire directly from the local Social Security office to the central processing system. This new system also contains fraud deterrent features, and will enable us to remove the blank Social Security card stock from local offices. (The blank Social Security card stock in the local offices was subject to theft and misuse for illegal activities.)

3. The idea of making the Social Security card tamper-proof has been discussed by a number of groups over the last several years in connection with the issue of work authorization for aliens. For example, the Select Commission on Immigration and Refugee Policy considered work authorization proposals at length. In its March 1981 report, however, the Select Commission stated that it was unable, even after considerable discussion, research, and debate, to reach a consensus as to the specific type of identification that should be required for work verification.

The Reagan Administration, in developing its legislative proposals on immigration and refugee policy, expressed opposition to the creation of a national identity card. Instead, the Administration proposed that proof of eligibility to work in this country could be demonstrated by presenting any two of a number of existing documents, such as a birth certificate or documentation issued by the Immigration and Naturalization Service.

The General Accounting Office (GAO) also has studied the issue of issuing Social Security cards. In its report, "Reissuing Tamper-Resistant Cards Will Not Eliminate Misuse of Social Security Numbers" (12/23/80), GAO concluded that issuing tamper-resistant Social Security cards will not correct the underlying conditions leading to Social Security card and number misuse, and would not be a substantial benefit to the Social Security program.

From a practical standpoint, there are a number of problems with the concept of a tamper-proof Social Security card. First, there is no such thing as a noncounterfeitable card. It is possible to make cards which are very difficult and costly to tamper with or counterfeit, but there is no card which can be made absolutely secure if the incentives for counterfeiting are great enough.

Second, even if an absolutely secure card could be developed, its validity depends upon the validity of documents a person presents to SSA as evidence of facts, such as identity and age, that are needed for issuance of the card. This documentation itself is subject to alteration and counterfeiting. (For example, it is relatively easy to obtain and use someone else's birth certificate. This birth certificate can then be used to obtain other identity documentation, such as a driver's license, and so on until a complete set of false identity documents is acquired.)

Third, a new tamper-proof card could not be effective as an identification document until it was issued to every cardholder. The reason is that as long as two types of Social Security cards are in circulation, employers and other parties at interest would have no way of knowing which type of card an individual should possess and would have to treat the old-type card as legitimate. To overcome this problem by reissuing a new tamper-proof card to the 200 million current cardholders, most of whom received their cards before 1978 when evidence of identity requirements for SSN applicants were tightened, would be expensive and time consuming administratively, would burden legitimate current cardholders unnecessarily, and would have a severe impact on State and local custodians of the records needed to verify age, identity, and citizenship. We estimate that verifying identities and issuing new cards made of banknote paper to all cardholders would cost approximately $860 million.

Fourth, for an employer to use a Social Security card as an identification document, the card should establish that it belongs to the person presenting it. The current card contains only a name, a Social Security number, and a space for the person to sign the card if he or she wishes. Thus, an employer has no way of knowing if a Social Security card actually belongs to the person being hired. We have considered suggestions to use a card with a photograph or physical description of the applicant and requiring that the card be signed when issued. However, these are not wholly effective positive identifiers because people can modify their appearance, and signatures can be reproduced with practice. In addition, pictures and signatures on the card would require updating from time to time—which would be expensive—because appearances and signatures change considerably over a lifetime and the majority of applicants for Social Security numbers are infants and young children. While Social Security cards could be reissued periodically, as are driver's licenses, the cost and public inconvenience of reissuing the cards to over 200 million people, say, every 5 years would be very great and would not be of any significant benefit to the Social Security program. More secure identifiers, such as fingerprints, require verification techniques that are expensive and that employers cannot themselves apply.

Questions by Senator Heinz and Nelson Sabatini's Responses

QUESTION 1:

In preparation for your appearance before the Committees on December 9, 1981, you were asked to track specific recommendations for program change suggested by HHS IG in 1980. What program change has resulted from the recommendations of the Inspector General in 1980? Please indicate in your response the date these changes were suggested, the date of implementation, and the date and manner of notification of the IG that these program changes were in progress. Please also detail the changes that were not implemented and the reasons they were not implemented.

ANSWER:

Summaries of action on each of these six OIG reports as of December 9, 1981, are attached. The reports are:

A. Procedures for Reimbursing GSA for Non-Recurring Reimbursable Work Authorizations

B. Problems Found in the Computer Process of the Social Security Number Enumeration System

C. State Practices on Refunding the Federal Portion of Recovered Overpayments

D. Title II Benefit Payment Withdrawals and Disbursements by SSA

E. Internal Controls Over Payment of Overtime

F. Service Delivery Assessment of the Low Income Energy Assistance Program (LIEAP)

A. Report Title: Review of Procedures for Reimbursing GSA for Non-Recurring Reimbursable Work Authorizations (Audit Number 13-02608)

Date Changes Recommended: March 31, 1980

Date of SSA Response to OIG: June 19, 1980

Overview : This report notes that when SSA requests repairs or improvements, GSA does not contract for the work until after it has received payment from SSA for the estimated cost. For FY 75-78 projects, the trust funds could have earned $447,000 in interest if payment had been made upon project completion rather than when requested.

Recommendation:

That SSA submit a proposal to GSA requesting 1) waiver of the advance payment requirement, and 2) approval to reimburse GSA on a percentage of completion basis for non-recurring work authorizations.

Action:

SSA moved promptly to implement this recommendation. We immediately requested a wiaver and got GSA to agree in principle. The procedures SSA recommended to GSA called for 1) not advancing cash until the project actually begins and 2) GSA providing periodic cost reports to SSA. Progress payments under each reimbursable work authorization would be compared to actual costs and refunds requested where 1) advances are excessive or 2) projects are terminated before their completion. Essentially, the arrangement proposed by SSA provides cash flowing to GSA to coincide with its level of need. After a one year delay GSA has now promised that the necessary new billing procedures will be issued and implemented in January 1982. SSA's finance and realty and space management staffs will coordinate oversight of costs and cash flow once GSA implements its new procedures.

Recommendation:

That SSA issue procedures for 1) monitoring actual costs of non-recurring projects to determine when refunds of excess payments should be requested from GSA, and 2) requesting prompt refunds for excess payments on projects terminated before their completion or completed at amounts less than the payments to GSA.

Action:

We have instituted a standard set of procedures to ensure greater oversight in the monitoring of costs. These procedures require GSA to submit cost breakdowns, shop drawings, and cost amendments to SSA prior to the granting of funding authorization. In addition, the procedures proposed to GSA in response to the first recommendation contained a request for refund when advances are excessive or projects terminated prior to completion.

B. **Report Title:** Assessment of Problems Found in the Computer Process of the Enumeration System (attachment to Shiela Brand's June 25, 1980, letter to Ted Murcheck)

Date Changes Recommended: June 25, 1980

Date of SSA Response to OIG: No response issued, as discussed below.

Overview : Shiela Brand of OIG participated in a risk assessment of the enumeration (social security card issuance) process that was conducted by SSA during 1980. The "vulnerabilities" identified by Ms. Brand were included in the risk analysis report, which was published by SSA's Office of Enumeration and Earnings Records in February 1981. These recommendations were not addressed by SSA separately, but as part of the overall risk analysis report.

Most of the recommendations in Ms. Brand's letter dealt with specific operational problems involving the processing of applications for social security cards. The enumeration process that was studied by Ms. Brand's risk analysis team will be replaced shortly by a greatly modified process, whereby social security number applications will be keyed into the system by local field offices, rather than being mailed into Baltimore. As a result, many of these recommendations will no longer be applicable. Others will continue to be relevant, however, and we are currently either working on implementation of those or analyzing them further to determine the best course of action.

The recommendations made by Ms. Brand were combined into the following nine safeguard recommendations in the overall risk analysis report:

Recommendation:

Change the electronic process to control and follow-up on exceptions produced by the system to ensure that all are reentered.

Action:

With the implementation of the new process, the reentry of exceptions will become a district office (DO) responsibility, and the problem cited will not apply.

Recommendation:

Reexamine all edit routines and improve as necessary.

Action:

The new enumeration process mentioned above has required a new set of edit routines, since the initial input is coming from a different source.

Recommendation:

The edit check of the district office (DO) code field should require a valid DO code.

Action:

The new process will automatically pick up the DO telecommunication address from the data communications terminal (called the hardware address); thereby eliminating the reported problem.

Recommendation:

Expand edit routines to identify all errors in a record rather than rejecting an input record as soon as the first error is discovered.

Action:

The new process will contain this capability.

Recommendation:

Maintain a backup copy of the master tape files, including each day's transactions, in an area removed from the data center.

Action:

SSA uses a secure, off-site, underground storage facility to store its master tape files and is developing a contingency plan that will ensure rapid recovery should something happen to all or part of the master files housed on magnetic media.

Recommendation:

The tape file that contains the actual SSN cards to be printed each night should contain the number of such records to be printed, contain internal checks to make sure no more than that number are printed, and produce information on these figures for management review.

Action:

These requirements are being analyzed by our systems components and will be incorporated in future systems changes.

Recommendation:

A code should be printed on the SSN card and the stub and stored in the electronic record to enable association should an investigation involving the record be necessary.

Action:

SSA has a long term effort underway to establish security audit trails (e.g., who handled an action, when, where, etc.). Unfortunately, these audit trails are expensive to establish and maintain. Our intent is to develop them for cash payment type transactions first, and if it proves cost effective, to apply them to SSN transactions. Also, SSA is studying this specific recommendation. We already have set up extensive audit trails within the new process.

Recommendation:

The SSN master record should indicate if the SSN card was returned by the Postal Service as undeliverable.

Action:

Such information could be useful in resolving subsequent problems with an account. This capability will not be present upon initial implementation of the new process, but requirements have been provided to our systems component to provide this facility.

Recommendation:

Improve the management information produced by the enumeration system.

Action:

The new process will produce more usable information about the enumeration operations.

C. Report Title: States Practices in Refunding Federal Portion of Recovered Overpayments and Uncashed Checks Under the AFDC Program (Audit Number 15-90250)

Date Changes Recommended: June 30, 1980

Date of SSA Response to OIG: December 12, 1980

Overview: The report notes that States' laws (and policies) vary considerably on the issues of 1) voiding State-issued checks that are not cashed by the beneficiaries, and 2) crediting the Federal programs for their share of these uncashed checks. In some States uncashed checks are voided after 60 days of issuance, while in other States the period is 5 years—or longer. Moreover, voiding or cancelling the checks doesn't necessarily result in refunds to the Federal program.

Recommendation:

Establish an overall uniform policy for timely return of the Federal portion of uncashed checks and other credits. Six months or less from date of issuance should be established as the time allowable for States to return the Federal portion of uncashed AFDC checks.

Action:

We alerted all of our regional offices to this recovery problem and they reviewed States' handling of uncashed checks--how long each one allows checks to remain outstanding; what types of follow-up the States have, if any, to determine the reasons for checks not being cashed. We then initiated action on a new Federal regulation to establish a uniform requirement for States to credit the Federal government for its portion of uncashed AFDC checks. A Notice of Decision to Develop Regulations for this purpose was published in the Federal Register in November 1980. We expect final regulations to be issued in mid-1982.

D. **Report Title:** Review of Title II Benefit Payment Withdrawals and Disbursements (Audit Number 13-12614)

Date Changes Recommended: October 15, 1980

Date of SSA Response to OIG: January 6, 1981

Overview: The Audit Agency (AA) calculated that amounts transferred from the Trust Funds to the Treasury to cover monthly title II benefit payments exceeded the amounts actually needed by some $53 million a month. The AA concluded that SSA could increase interest earnings of the Trust Funds by $4.5 million a year if more precise methods of determining the amounts needed were used. In addition the auditors thought more needed to be done to resolve the difference between the payments certified to Treasury and the computer system accounting totals.

Recommendation:

Require the program service centers (PSC's) to promptly prepare and transmit to the Division of Finance via telecommunications or similar equipment, the Daily Reports of Benefit Activity (forms SSA-2049).

Action:

This recommendation has been implemented. The PSC's are now transmitting the forms SSA-2049 to the Office of Management and Budget's Division of Finance on a daily basis via the telecommunications equipment (Facsimile Telecopier).

Recommendation:

Determine needed Trust Funds withdrawals by utilizing daily benefit data recorded on the forms SSA-2049.

Action:

SSA [illegible] - wh [illegible]

This recommendation has been implemented. Trust Fund withdrawals are now being made using the data contained on the forms SSA-2049.

Recommendation:

Coordinate with the Treasury Department the procedures needed to effect Trust Funds drawdowns on an "as needed" rather than weekly basis.

Action:

We have coordinated with Treasury and, since November 1, 1980, we have been making daily withdrawals from the Trust Funds effective with the date of actual benefit activity as shown on the SSA-2049s received from the program service centers. We contact Treasury daily to inform them of the necessary withdrawal amount.

Recommendation:

Ensure that the causes of the imbalance identified in comparing accounting systems totals to payment data forwarded to the Treasury are documented.

Action:

Although we agree that the method of documenting imbalance conditions needs improvement, the complexity of the changes that would be necessary to accomplish the redesign of the system are too great compared to the benefits to justify inclusion of the redesign as a priority item in SSA's 1982 ADP Plan. The redesign will compete with other projects for later inclusion in the ADP Plan.

Recommendation:

Analyze the causes for the imbalances and take action needed to correct the system to avoid their recurrence.

Action:

With few exceptions we identify the causes of all imbalance conditions. When the cause is identified, immediate action is taken to correct the program so as to prevent further occurrence of any erroneous processing.

Recommendation:

Automate the manual balancing operation currently performed by the Payment Certification and Accounting Unit in Office of Central Operations.

Action:

The balancing operation has been extensively automated. As a result the number of employees involved in the operations has been drastically reduced; at the present time only five accounting technicians are required to handle that part of the operation which remains non-automated.

Present non-automated processes exist only because the data is created in separate and unrelated computer systems. As new systems are developed, we will make every attempt to make them compatible so as to ultimately arrive at a fully automated data collection, balancing, certification, and reporting system. However, such systems will have to be included in SSA's ADP Plan and, although the project has wide acceptance, it is currently impossible to project when it will be included in the plan due to competing priorities.

E. Report Title: Follow-Up Review of Internal Controls Over Payment of Overtime (Audit Number 12-13076)

Date Changes Recommended: December 3, 1980

Date of SSA Response to OIG: Not applicable as discussed below

Overview: This review, done at Secretary Schweiker's request, is a follow-up to an OIG report issued in December 1980 critical of HHS overtime practices and controls. In this new report, addressed to the Assistant Secretary for Personnel Administration, OIG notes that improvements have been made in requesting, approving and documenting overtime, but problems persist relating to 1) absence of written requests and approvals of overtime, 2) unsigned authorization forms, 3) inadequate or no documentation for overtime and 4) overtime worked at home. The report also concludes that inadequacies remain in the separation of time and attendance duties. SSA is mentioned as having overtime authorization practices that are inconsistent with Department guidelines.

Action:

Although the audit report and its recommendations were directed to the Assistant Secretary for Personnel Administration, SSA took prompt action on it and on the Secretary's February 1981 directive on overtime. SSA's actions included:

--conduct of the internal compliance reviews as directed by the Secretary;

--issuance of reminders to managers on overtime policies;

--development of a new training program in video cassette format for timekeepers;

--development of a checklist for certifying officers to assist them in fulfilling their responsibilities;

--revising instructions to supervisors on premium pay;

--preparing new redelegations for authorizing overtime;

--redesigning sign-in sheets to accommodate the new requirement for written approval by the secondline supervisor for individuals to work overtime;

--dissemination of time and attendance management reports to assist managers in monitoring individual employee overtime usage and compliance with tour of duty hour limitations.

F. Report Title: *Low Income Energy Assistance Program* (LIEAP) A Service Delivery Assessment (June 16, 1980)

Date Recommendations Made/Responded To: Not applicable as explained below.

Overview: The LIEAP was enacted to assist low income people with the increased costs of energy during the winter months. This service delivery assessment was conducted to provide client and local provider feedback on the operation of this new program. Further, it was to provide early warnings of problems in the implementation of LIEAP and to identify major issues for future program considerations. The report deals primarily with the Special Energy Allowance and Energy Assistance Program portions of LIEAP. The SDA report on '80 is not applicable due to subsequent changes in the law.

Recommendations:

This particular SDA did not make any specific recommendations though it did raise a number of specific issues. These issues were addressed by Congress in its enactment of the Home Energy Assistance Act of 1980 (title III, P.L. 96-223). SSA subsequently took action by its publication of FY 1980 LIEAP regulations. The sections listed below address the effect of those regulations and the remedial action taken by SSA on the issues raised by the FY 1980 SDA affecting fraud, waste, and abuse.

Action:

--In FY 1981 the States had to take into account the specific energy costs of an eligible household in computing benefit amounts (206.154). This provision addressed the concern that in FY 1980 categorical programs were not targeting aid to fuel bills.

--In FY 1981 households within any State were to receive similar amounts of assistance if they were similarly situated with respect to energy costs, income, and other considerations relevant to assistance (260.154). This provision addressed the concern that in FY 1980 similarly situated eligible households in a State were receiving different amounts of payments.

--In FY 1981 home energy suppliers receiving assistance payments on behalf of eligible households were required to sign agreements with their States (unless exempted) which provided assisted households with certain assurances (260.250). States were required to monitor such agreements with home energy suppliers and to secure documentation of energy supplied to eligible households (260.64). These provisions addressed the concern in FY 1980 that better ways be found to insure fuel vendor accountability.

--In FY 1981 States were required, to the maximum extent possible, to refer eligible LIEAP households to existing Federal, State, and local weatherization and conservation services (260.58). This provision addressed the concern in FY 1980 that more coordination of services was needed.

--In FY 1981 States were required to report on a variety of LIEAP program expenditures, including administrative costs (260.82). In part, such fiscal reporting allows for the possibility of identifying cost-effective approaches to LIEAP service delivery as supported by the FY 1980 SDA.

-- Regulations were drafted to ensure that the elderly and handicapped were given priority.

QUESTION 2:

What other changes in program operation have resulted from the IG's recommendations to this date? *Please identify by program, date of suggestion (month and year), date of implementation and change.*

ANSWER

The Inspector General's Office has issued numerous reports and recommendations which have led to changes in SSA operations. OIG recommendations and SSA actions from the following selected reports issued in 1980 (in addition to those described in the previous response) the following reports which describe actions SSA has taken are shown below:

A. Procedures for Controlling and Accounting For Audit Disallowances

B. Transmission and Accounting For Benefit Payments by SSA's Southeastern Program Service Center

C. Physical Access to the ADP Secure Area

D. Administrative Use of the ADP Security System

E. Documentation for 1978 Average Wage Determinations

A. **Report Title:** Procedures for Controlling and Accounting for Audit Disallowances (Audit Number 13-02623)

Program: All programs

Date Changes Recommended: May 7, 1980

Date of SSA Response to OIG: July 20, 1980

Overview: Costs claimed by and paid to State agencies to administer aspects of SSA programs are audited by the OIG Audit Agency. Claims which the auditors recommend be disallowed--and which SSA agrees with the auditors on--are referred to as "audit disallowances" and are to be recorded as accounts receivable. In 1977 HHS's finance office set out procedures for processing audit disallowances. Based upon audit work done in 1978, OIG concluded that improvements were needed in SSA's implementation of those procedures.

Recommendation:

SSA's Division of Audit Management and Liaison and Division of Finance should coordinate to:

--Record as accounts receivable the $45.5 million outstanding audit disallowances at September 30, 1978 and properly account for applicable recoveries and waivers as required by Departmental directives;

--Determine and properly account for sustained disallowances, recoveries and waivers since September 30, 1978;

--Develop internal procedures to ensure that audit clearance documents are prepared timely and properly routed by program action officials;

--Implement procedures to promptly obtain accounting identification information omitted from audit clearance documents;

--Develop methods and assign responsibility for making prompt recovery of sustained audit disallowances.

Action:

This recommendation has been implemented. All open audit disallowances are being recorded as receivables in the accounting system. Recoveries and waivers are also being properly recorded, and SSA is aggressively pushing efforts to collect these debts. Instructions for processing OIG audit reports are contained in a guide that is part of SSA's Administrative Directives System. This guide also sets out the steps program officials should follow to assure that audit clearance documents are prepared on time and are properly routed.

B. Report Title: Tranmission and Accounting for Benefit Payments by SSA's Southeastern Program Service Center (Audit Number 04-02601)

Program: Retirement, Survivors and Disability Insurance

Date Changes Recommended: August 19, 1980

Date of SSA Response to OIG: November 20, 1980

Overview: RSDI payment data is processed from the Central Office computer system to the Program Service Center where it is verified and certified and shipped to Treasury's Regional Disbursing Center to write the checks. About 15 percent of all RSDI checks are processed through the Southeastern PSC. OIG found weaknesses in controls at the Southeastern PSC over the transmission of daily and monthly payment data to Treasury and the adequacy of the accounting system.

Recommendation:

--Periodically change the combination to the door of the computer operations facility and give the combination only to personnel requiring routine access to the area. All other persons entering the area should sign in-and-out logs and be accompanied by an escort.

--Discontinue the practice of allowing computer programmers unrestricted access to the computer area.

--Determine the feasibility of increasing the security over access to the computer facility through use of special identifcation cards that would have to be inserted into the access door to gain entry.

Action:

SSA agreed and notified OIG that these actions had been taken.

Recommendation:

--Keep the payment tapes in the custody of the tape librarian until picked up by the courier.

--Establish a control that would allow for monitoring the pick-up and delivery times between the PSC and the RDC to ensure that the tapes are delivered expeditiously.

--Discontinue the enroute stops when delivering the payment tapes to the RDC.

Action:

SSA agreed. The pick-up location of the tapes has been changed to the secured computer area and changes have been made with the courier to ensure direct delivery of the tapes to the RDC without intermediate stops.

Recommendation:

Provide training to the certifying officers on their duties and responsibilities.

Action:

SSA agreed and reminded certifying offices to review and make sure they understand the duties and responsibilities of the job.

C. Report Title: Physical Access to the ADP Secure Area (13-02607)

Program: All SSA programs

Date Changes Recommended: September 22, 1980

Date of SSA Response to OIG: February 6, 1981

Overview: SSA computer operations are housed in a physically secure area. OIG found that protection of SSA computers and computer records was reduced because access to the ADP secure area had not been effectively limited. The auditors found that passes to get into the secure area were being issued too freely and not being revoked upon retirement, and that security was hampered because the security function was divided between OA and OMBP. Their report contained many detailed recommendations for corrective action.

Recommendation:

All organizations that request entry badges to the ADP secure area for their employees should be informed what is needed to properly prepare these applications.

Action:

SSA notified OIG that a revised application form dated February 1980 has been put into use. The new form itself contains instructions on how to prepare the application.

Recommendation:

Definitive procedures should be written to assist personnel who review requests for ADP entry badges in determining whether or not adequate justification for access into the secure area has been made.

Action:

Definitive procedures were drafted and implemented in early 1981.

Recommendation:

--The security staff should periodically monitor and reevaluate the need for individuals to have access to the secure area.

--Permanent and temporary badges currently issued to personnel whose duties do not involve computer support and whose work locations are outside the secure area should be immediately reevaluated to determine whether badges should be revoked.

Action:

OIG was notified in February 1981 that these recommendations had been implemented.

Recommendation:

Standards governing admittance to the secure area should be established based on the relative sensitivity of ADP positions as described in Federal Personnel Manual (FPM) Letter 732-7.

Action:

As OIG has been informed, SSA is continuing to await OPM finalization of Government sensitivity-designation standards, which we believe is a prerequisite to imposing sensitivity-designation standards at this agency.

Recommendation:

The Security Control Staff should be informed whenever any badge holder is about to retire, relocate, or otherwise lose access rights, and the badge should be immediately turned in to them.

Action:

This requirement has been incorporated in draft ADP pass procedures and will appear on the next printing of the pass application form itself.

Recommendation:

Badges that are turned in should be immediately invalidated so as to preclude unauthorized use.

Action:

This recommendation had been implemented by the time the report was issued.

Recommendation:

The Security Control Staff should be trained in basic security practices and in the operating techniques and capabilities of the computers supporting the electronic security system.

Action:

This training was carried out in 1980.

Recommendation:

The position of ADP marshal should be phased out as quickly as practicable.

Action:

SSA agreed, and this has been done.

Recommendation:

SSA should remind Federal Protective Officers that they are required to open and inspect trash bags before they are removed from the secure area.

Action:

This was done as soon as the auditors brought the problem to SSA's attention.

Recommendation:

--SSA should establish personnel security policies for screening all individuals including contractor personnel participating in the design, operation or maintenance of computer systems, or having access to that data.

--The level of screening for ADP personnel should vary from minimal checks to full background investigation depending on the harm an individual can cause and not because of his/her position.

Action:

As briefly noted in response to an earlier recommendation, an interagency task force under OPM was charged with developing Government-wide sensitivity designations. OPM has not yet finalized these standards. SSA agrees in principle with the recommendations but implementation action continues to hinge on promulgation of the Government-wide standards.

Recommendation:

All individuals who enter the secure area should be made aware of the provisons of the Privacy Act of 1974.

Action:

SSA agreed with this recommendation and implemented it.

Recommendation:

Individuals who enter the secure area should attest to their understanding of their duties and their knowledge of the penalties for noncompliance by signing an affadavit.

Action:

This requirement is being included in the next printing of the security pass application form.

Recommendation:

Programmers should be authorized temporary badges that are valid only on occasions and at times when the programmer is requested to enter the secure area.

Action:

This recommendation was promptly implemented.

Recommendation:

SSA should take more aggressive action to have all test tapes located at the computer room returned to the tape library.

Action:

SSA agreed with the auditors and has actively pursued ways to tighten up on tape controls.

Recommendation:

--Requests for emergency ADP processing should be approved by division heads or their designees before requests are made to ADP.

--Personnel in ADP should not accept emergency requests unless they have been authorized by cognizant officials. Also, emergency requests should not be processed unless they have been approved and accepted by personnel designated to do so.

Action:

A new administrative guide was published to strengthen the rules on "emergency" ADP processing, which the auditors found was being used in routine, non-critical situations. Emergency requests must now be approved by the cognizant branch chief in our Office of Systems.

Recommendation:

--Use of the Significant Incident Report (SIR) procedure should be encouraged and action taken to investigate and correct the problems reported.

--Whenever a SIR is filed, proper feedback should be given on what has been done and furnished directly to the individual that reported the incident.

Action:

The auditors found that people were not filling out an "incident" report when an ADP processing job did not go off right--partly because they were not getting adequate feedback on the reports they did file. Besides stressing the importance of using the report to ADP operators, corrective action included a new User Coordination and Job Expediting Section to facilitate resolution of problems and get back to the originator on all SIR's.

Recommendation:

Top GSA officials should be contacted whenever emergency conditions are not resolved promptly and effectively by onsite GSA personnel. On these occasions, a waiver should be requested permitting SSA to act on its own to correct the problem.

Action:

GSA emergency service has attained a satisfactory level since the audit was done, and onsite SSA-GSA coordination mechanisms seem to be working effectively.

D. **Report Title:** Administrative Use of the ADP Security System (Audit Number 13-02636, September 30, 1980)

Program: Administrative

Date Recommendations Made/Responded To: Not Applicable

Overview: OIG examined time and attendance records of employees in the ADP secure area during an 11 day period. Results indicated that employees spent about 12 percent of their work hours (exclusive of lunch and breaktime) outside the ADP area. OIG did not make any specific recommendations, but tracked SSA's own progress in trying to use its ADP Security System for administrative purposes. This is a computerized system which identifies individuals entering and exiting the computer facility and the time and date of entry or exit. In addition to providing security, supervisors could use this system to verify actual employee presence and to detect unauthorized employee absences from the work area. However, the auditors noted that only security personnel have access to the system's records and that access has been restricted to use for security purposes.

Action:

On December 11, 1980, SSA notified OIG that a systems change notice would be published in the Federal Register to permit this use of the security system, subject to successful resolution of the matter with the local union. That resolution has now been achieved and the proposed Federal Register notice (a Privacy Act requirement) is now being reviewed within HHS. The notice is expected to be published in February 1982, after which SSA will start using the system to verify time and attendance.

E. **Report Title:** Documentation For 1978 Average Wage Determinations (Audit Number 13-02636)

Program: Retirement, Survivors, and Disability Insurance

Date Changes Recommended: September 30, 1980

Date of SSA Response to OIG: January 12, 1981

Overview : SSA computes average annual wages received by American workers. The figures are used to index past earnings in computing Social Security benefits and to calculate certain threshold levels such as minimum earnings needed to earn Social Security coverage. OIG reported that they were unable to verify the 1978 computation because it was not supported by adequate auditable documentation internal controls. The report made three recommendations for better documentation in the future.

Recommendation:

Maintain documentation supporting the computation of the 1978 and future average annual wage amounts for a minimum of three years.

Action:

SSA concurred and asked IRS to start doing this. On March 9, 1981, SSA was notified that IRS had begun retaining tapes for three years as requested, starting with the 1981 tape.

Recommendation:

Execute with IRS formal agreement that delineates the specific information needed by SSA, requires IRS to explain how the data was obtained, and requires IRS certification of the accuracy and propriety of the data provided SSA.

Action:

SSA agreed with the auditors. As a result, SSA and IRS now formally concur in the overall programming specifications for computation of average wage data. However, SSA was unable to reach agreement with IRS on their providing detailed information on their internal processing or on their certifying the accuracy of the data.

Recommendation:

Require the Office of the Actuary to formalize agreement with the Office of Systems and other SSA components supporting information used in computing the average total wage amounts, describing specific controls to assure the reliability and completeness of data used in average wage computations.

Action:

SSA agreed and promptly formalized internal agreements in line with this recommendation.

QUESTION 3:

Is there a valid reason the program integrity personnel of SSA should be treated differently in their relationship to the IG than similar personnel within HCFA? If so, please specify. Specifically, why should SSA program integrity personnel be conducting criminal investigations?

ANSWER:

The differences between the handling of most potential fraud cases under programs of the Health Care Financing Administration and those of the Social Security Administration arise from the different nature of the violations involved. Potential violations in the HCFA programs almost always involve third parties - nursing home operators, pharmacists, hospitals, physicians, etc. - while those which the Social Security Administration investigates involve, in almost all cases, an individual program beneficiary who has allegedly violated one of the provisions of the program which affects his individual eligibility for a payment or payments. In fact, a Memorandum of Understanding between the Inspector General and the Health Care Financing Administration dated August 12, 1977, provides that "primary responsibility for investigation and referral of beneficiary recipient fraud" will rest with HCFA. This is the same division of responsibility that the IG and SSA have agreed to - the difference is that HCFA has almost no beneficiary cases while SSA has a great many. (Beneficiary fraud is infrequent in the Medicare program. To the extent beneficiary fraud exists in the Medicaid program, it is investigated by the States, not HCFA.)

The arrangement the IG made with SSA is spelled out in the operating statement dated September 1979 agreed to between the Inspector General and the Social Security Administration (copy attached). The operating statement provides that SSA will investigate suspected violations which are usually routine beneficiary or recipient cases and that SSA will refer to OIG for investigation or advise OIG of any nonroutine program violation case including certain specified types of violations which are enumerated in the statement. The reasons for this division of responsibility and the assignment by the Inspector General of the responsibility to investigate applicant or beneficiary cases to SSA relate to the characteristics of this workload:

- There are a large number of such cases. In fiscal year 1981, 10,253 suspected beneficiary program violations were referred to SSA's Integrity Staffs--nearly all coming from SSA district offices and processing centers.

- The amount of money involved in individual cases is comparatively small, typically an overpayment of several hundred to three or four thousand dollars.

- The violations usually results from the beneficiary concealing or misstating some fact which affects his or her own eligibility, and therefore, the violation is closely connected to program administration, and program information is usually an important element in developing the case.

- In view of the large number and geographical dispersion of cases, SSA district office people are frequently used to gather some of the needed evidence, especially when it can be obtained from public records or third parties.

The investigations conducted by the Integrity Staffs of the Social Security Administration are called "criminal investigations," in a technical sense, since they are potential violations of the penalty provisions of the Social Security Act or of some provision(s) of Title 18 of the U.S. Code. They are, however, as already indicated, a very restricted class of "criminal" cases. As both the HCFA and SSA agreements indicate, the OIG opted not to handle routine beneficiary cases which generally do not involve sophisticated or complex criminal activities.

The operating statement which assigns responsibility for these kinds of cases to SSA specifies that when other situations involving large-scale activities, complex situations, widespread investigations or organized crime are involved, SSA will refer these cases to the Inspector General (although SSA may continue to participate in the investigation under the leadership of the Inspector General's Office).

OPERATING STATEMENT

OFFICE OF INVESTIGATIONS/OFFICE OF THE INSPECTOR GENERAL

AND THE

SOCIAL SECURITY ADMINISTRATION

I. PURPOSE

The purpose of this document is to delineate the responsibilities of the Social Security Administration (SSA) and the Office of Investigations (OI), Office of the Inspector General (OIG) with respect to the handling of suspected criminal violations involving SSA programs or employees. It also provides guidelines to be used by SSA and OI in the processing of such cases.

II. INVESTIGATION OF PROGRAM VIOLATIONS NOT INVOLVING HEW EMPLOYEES

A. Retirement, Survivors, and Disability Insurance (Title II), Supplemental Security Income (Title XVI), and Black Lung Programs and Related Activities

1. SSA will investigate suspected violations involving the cited programs and activities related to such programs (usually routine beneficiary/recipient cases). SSA will make referrals directly to United States attorneys for consideration of prosecution. Indications of such violations first received by OI will be referred to SSA for processing, unless OI chooses to assume jurisdiction in particular cases.

2. SSA will refer to OI for investigation or advise OI of any nonroutine program violation case, including but not limited to those involving:

   a. Large-scale activities of persons who help or represent others in connection with applications or claims, and who are suspected of criminal violations in connection therewith.

   b. Persons of high repute in the community or other highly sensitive situations in which prompt investigation is necessary.

   c. Unusually complex situations requiring expertise not available within SSA.

   d. Multiple service areas or regions when it is desirable that a single investigator handle the complete investigation.

   e. Organized crime.

B. Aid to Families with Dependent Children Program (Title IV-A) Violation Cases

The Aid to Families with Dependent Children (AFDC) program is administered by State agencies under Federal regulations and guidelines. In cooperation with State law enforcement authorities, the State agency establishes methods and criteria for investigating and referring suspected AFDC program violations to law enforcement officials for prosecution under State law. Federal oversight for the title IV-A programs is the responsibility of SSA. OI can, at its discretion, involve itself in AFDC violations to the extent necessary to carry out its responsibilities to coordinate and direct fraud investigations in HEW programs. Conversely, SSA may request the assistance of OI in any AFDC case where OI involvement appears warranted.

III. INVESTIGATION OF CRIMINAL VIOLATIONS INVOLVING HEW EMPLOYEES

A. SSA will refer to OI for investigation and/or presentation to a U.S. attorney all cases not covered by (B) below involving SSA and other HEW employees. This includes cases in which preliminary development discloses evidence that an employee criminally violated a provision of:

1. The Social Security Act.
2. Title 18 of the United States Code (a codification of statutes involving crimes against the United States).
3. The Privacy Act.

B. SSA will investigate and/or refer to law enforcement officials, as appropriate, cases involving employees suspected of plain theft (not embezzlement) of or on government property, drug abuse, false fire alarms, assault, bomb threats, gambling, and other acts of misconduct. However, any allegations of theft or other criminal acts by an employee or group of employees, in which a breach of the employee's or employees' position of trust is involved, will be referred to OI.

C. OI may, on an ad hoc basis, request SSA to conduct investigations of suspected program violation cases involving SSA and other HEW employees. For example, employee cases identified through special activities, such as Project Match, involving SSA programs may be sent to SSA for investigation.

IV. OPERATIONAL AND ADMINISTRATIVE MATTERS

A. Case Referral Procedures

1. Referrals by SSA to OI in accordance with Part II of this agreement generally will be made at the regional level by the Field Assessment Office, Office of Assessment. Similarl OI referrals to SSA generally will be made at the regional level, and will be directed to the Field Assessment Office, Office of Assessment.

2. Referrals by SSA to OI in accordance with Part III of this agreement generally will be made at the regional level by the Field Assessment Office, Office of Assessment. However, if the case involves a headquarters employee, an employee appointed under Section 3105 of Title 5, United States Code (i.e., an Administrative Law Judge), or a violation of the Privacy Act of 1974, the case will be referred to the appropriate OI office by the Office of Security and Program Integrity, Office of Assessment.

3. Upon receiving notification of a suspected criminal violation involving an employee, OI has the responsibility for timely notification of the Attorney General in accordance with 28 U.S.C. 535. Upon completion of investigation of such cases, OI will, if the evidence and circumstances warrant, present the case to a U.S. attorney for consideration of prosecution.

4. Specific operational questions involving cases being processed by SSA requiring discussion with OI will be handled by the appropriate SSA operating official.

B. SSA Notification

In recognition of the need for such information for SSA administrative purposes:

1. OI will promptly notify SSA of any case in which it unilaterally assumes jurisdiction under Part II of this agreement.

2. OI will, in all SSA cases it investigates, send SSA a copy of the Report of Investigation when the case is closed by OI. If OI refers the case to a U.S. attorney for prosecution, it will concurrently notify SSA of such action and transmit to SSA a copy of the investigation summary. Upon disposition of the case by a U.S. attorney or a U.S. district court, OI will notify SSA of the results and transmit to SSA a copy of the Report of Investigation. (Rule 6(e) of the Rules of Criminal Procedure for the United States District Courts may prohibit OI disclosure of certain information related to Grand Jury proceedings.)

3. The materials furnished SSA by OI in accordance with (1) and (2) above will be sent to the following offices:

    a. Cases handled at the regional level will be sent to the appropriate SSA Field Assessment Office. In addition, a copy will be sent to: Office of Security and Program Integrity, Office of Assessment, Social Security Administration, Baltimore, Maryland 21235.

b. Cases handled at the central office level will be sent to: Office of Security and Program Integrity, Office of Assessment, Social Security Administration, Baltimore, Maryland 21235.

C. Resolution of Issues

Matters of mutual interest to SSA and OI not covered by this agreement, and any issues arising in connection with interpretation of this agreement, will be addressed and resolved at the central office level.

D. SSA Control Point for OI Investigative Activities

The Office of Security and Program Integrity, Office of Assessment, will represent SSA on issues involving investigative activities and serve as control point for referral of cases between OI and SSA central office.

Richard B. Lowe III
~~Thomas D. Morris~~
Acting Inspector General

9/12/79
(DATE)

Stanford G. Ross
Stanford G. Ross
Commissioner of Social Security

9/10/79
(DATE)